Contract Number 151473

AMENDMENT TO
STATE OF OREGON
PERSONAL/PROFESSIONAL SERVICES CONTRACT

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This is amendment number **2** to Contract Number **151473** between the State of Oregon, acting by and through its Oregon Health Authority, hereinafter referred to as "OHA" and

APS Healthcare Quality Review, Inc.
abn KEPRO, Inc.
777 East Park Drive
Harrisburg, PA 17111
Telephone: (717) 564-8288 Ext. 7026
E-mail address: jdougher@kepro.com
www.kepro.com

hereinafter referred to as "Contractor."

1. This amendment shall become effective on the date this amendment has been fully executed by every party and, when required, approved by Department of Justice.

2. The Contract is hereby amended as follows:

a. The OHA contact information listed on Page 1 is deleted and replace with the following:

Health Systems Division
Provider Clinical Support
500 Summer Street NE
Salem, OR 97301
Contract Administrator: Chad Scott or delegate
Telephone: (503) 947-2315
Facsimile: (503) 945-6548
E-mail address: chad.d.scott@state.or.us

b. Section 3 "Consideration" is hereby amended to change the maximum not-to-exceed from $26,829,270.00 to **$27,289,270.00.**

c. Exhibit A, Part 1 Definitions, Section 22. is amended as follows, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**:

"**22. "Home and Community Based Services"** or **"HCBS" are Home and Community-Based Services (HCBS) opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other isolated settings.** ~~mean the services provide approved and funded by the Centers for Medicare and Medicaid Services for eligible individuals who are aged and physically disabled and for eligible individuals with intellectual disabilities and developmental disabilities in accordance with Title XIX of the Social Security Act. (OAR 411-048-0160 (19)) and for eligible individuals who are aged and physically disabled the HCBS is provided in accordance with State Plan K Community First Choice requirements. (OAR 411-046-0110 (25))~~"

d. **Exhibit A, Part 2 - Statement of Work** is hereby amended as set forth in the attached **Attachment 1**, which is hereby incorporated by reference, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**.

e. **Exhibit A, Part 3 – Payment and Financial Reporting** is hereby amended, for services rendered after the effective date of this amendment, as set forth in the attached **Attachment 2**, which is hereby incorporated by reference, language to be deleted or replaced is ~~struck through~~; new language is **underlined and bold**.

f. **Exhibit B**, **Standard Terms and Conditions**, Section **21. "Notice" OHA** address only, is amended as follows: Deleted language is ~~struck through~~ and new language is **underlined and bold**.

OHA: Office of Contracts & Procurement
~~250 Winter Street, Room 309~~
635 Capitol Street NE, Suite 350
Salem, OR 97301
Telephone: 503-945-5818
Facsimile: 503-378-4324

g. **Exhibit D, "Federal Terms and Conditions"** is hereby superseded and restated in its entirety, as set forth in the attached **Attachment 3** which is hereby incorporated by reference.

3. Contractor shall comply with all federal, state and local laws, regulations, executive orders and ordinances applicable to Contractor and the Contract. OHA's performance under the Contract is conditioned upon Contractor's compliance with the obligations of contractors under ORS 279B.220, 279B.230 and 279B.235, which are incorporated by reference herein.

4. Except as expressly amended above, all other terms and conditions of the initial Contract and any previous amendments are still in full force and effect. Contractor certifies that the representations, warranties and certifications contained in the initial Contract are true and correct as of the effective date of this amendment and with the same effect as though made at the time of this amendment.

5. **Certification.** Without limiting the generality of the foregoing, by signature on this Contract Amendment, the undersigned hereby certifies under penalty of perjury that:

a. Contractor is in compliance with all insurance requirements in Exhibit C of the original Contract and notwithstanding any provision to the contrary, Contractor shall deliver to the OHA Contract Administrator (see page 1 of the original Contract) the required Certificate(s) of Insurance for any extension of the insurance coverage required by Exhibit C of the original Contract, within 30 days of execution of the Contract Amendment. By certifying compliance with all insurance as required by this Contract, Contractor acknowledges it may be found in breach of the Contract for failure to obtain required insurance. Contractor may also be in breach of the Contract for failure to provide Certificate(s) of Insurance as required and to maintain required coverage for the duration of the Contract;

b. Contractor acknowledges that the Oregon False Claims Act, ORS 180.750 to 180.785, applies to any "claim" (as defined by ORS 180.750) that is made by (or caused by) the Contractor and that pertains to this Contract or to the project for which the Contract work is being performed. Contractor certifies that no claim described in the previous sentence is or will be a "false claim" (as defined by ORS 180.750) or an act prohibited by ORS 180.755. Contractor further acknowledges that in addition to the remedies under this Contract, if it makes (or causes to be made) a false claim or performs (or causes to be performed) an act prohibited under the Oregon False Claims Act, the Oregon Attorney General may enforce the liabilities and penalties provided by the Oregon False Claims Act against the Contractor;

c. The undersigned is authorized to act on behalf of Contractor and that Contractor has complied with the tax laws of the State of Oregon and the applicable tax laws of any political subdivision of Oregon. Contractor shall, throughout the duration of this Contract and any extensions, comply with all tax laws of Oregon and all applicable tax laws of any political subdivision of Oregon. For the purposes of this Section, "tax laws" includes: (i) All tax laws of Oregon, including but not limited to ORS 305.620 and ORS chapters 316, 317, and 318; (ii) Any tax provisions imposed by a political subdivision of Oregon that applied to Contractor, to Contractor's property, operations, receipts, or income, or to Contractor's performance of or compensation for any work performed by Contractor; (iii) Any tax provisions imposed by a political subdivision of Oregon that applied to Contractor, or to goods, services, or property, whether tangible or

intangible, provided by Contractor; and (iv) Any rules, regulations, charter provisions, or ordinances that implemented or enforced any of the foregoing tax laws or provisions.

Contractor acknowledges that the Oregon Department of Administrative Services will report this Contract to the Oregon Department of Revenue. The Oregon Department of Revenue may take any and all actions permitted by law relative to the collection of taxes due to the State of Oregon or a political subdivision, including (i) garnishing the Contractor's compensation under this Contract or (ii) exercising a right of setoff against Contractor's compensation under this Contract for any amounts that may be due and unpaid to the State of Oregon or its political subdivisions for which the Oregon Department of Revenue collects debts;

d. The information shown in "Contractor Data and Certification", of original Contract or as amended is Contractor's true, accurate and correct information;

e. To the best of the undersigned's knowledge, Contractor has not discriminated against and will not discriminate against minority, women or emerging small business enterprises certified under ORS 200.055 in obtaining any required subcontracts;

f. Contractor and Contractor's employees and agents are not included on the list titled "Specially Designated Nationals" maintained by the Office of Foreign Assets Control of the United States Department of the Treasury and currently found at: *https://www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx*;

g. Contractor is not listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal procurement or Non-procurement Programs" found at: *https://www.sam.gov/portal/public/SAM/*;

h. Contractor is not subject to backup withholding because:

(1) Contractor is exempt from backup withholding;

(2) Contractor has not been notified by the IRS that Contractor is subject to backup withholding as a result of a failure to report all interest or dividends; or

(3) The IRS has notified Contractor that Contractor is no longer subject to backup withholding; and

i. Contractor hereby certifies that the FEIN or SSN provided to OHA is true and accurate. If this information changes, Contractor is also required to provide OHA with the new FEIN or SSN within 10 days.

6. **Contractor Data.** This information is requested pursuant to ORS 305.385.

PLEASE PRINT OR TYPE THE FOLLOWING INFORMATION

Contractor Name (exactly as filed with the IRS): APS Healthcare Quality Review, Inc.

dba KEPRO, Inc.

Street address: 777 East Park Drive

City, state, zip code: Harrisburg, PA 17111

Email address: jdougher@kepro.com

Telephone: (717) 564-8288 Facsimile: (717) 564--3862

Is Contractor a nonresident alien, as defined in 26 U.S.C. § 7701(b)(1)?
(Check one box): ☐ YES ☒ NO

Business Designation: (*Check one box*):

☐ Professional Corporation	☐ Nonprofit Corporation	☐ Limited Partnership
☐ Limited Liability Company	☐ Limited Liability Partnership	☐ Sole Proprietorship
☒ Corporation	☐ Partnership	☐ Other

Contractor Proof of Insurance. Contractor shall provide the following information upon submission of the signed Contract Amendment. All insurance listed herein and required by Exhibit C of the original Contract, must be in effect for the term of the Contract.

If Contractor is self-insured for any of the Insurance Requirements specified in the original Contract, Contractor may so indicate by: (i) writing "Self-Insured" on the appropriate line(s); and (ii) submitting a certificate of insurance as required in Exhibit C of the original Contract.

Professional Liability Insurance Company: Travelers Casualty and Surety Co. Of America

Policy #: 106295684 Expiration Date: 06/01/18

Commercial General Liability Insurance Company: Travelers Indemnity of America

Policy #: 6306G63143A Expiration Date: 01/01/19

Automobile Liability Insurance Company: Travelers Indemnity Co.

Policy #: 6G622721-18-GAG Expiration Date: 01/01/19

Workers' Compensation: Does Contractor have any subject workers, as defined in ORS 656.027? *(Check one box):* ☒ YES ☐ NO *If YES, provide the following information:*

Workers' Compensation Insurance Company: Travelers Property Casualty Co. of America

Policy #: UB9H906270 Expiration Date: 01/01/19

7. Signatures.

CONTRACTOR: YOU WILL NOT BE PAID FOR SERVICES RENDERED PRIOR TO NECESSARY STATE APPROVALS.

APS Healthcare Quality Review, Inc.
By:

Authorized Signature	Joseph A. Dougher Printed Name
President & CEO Title	February 12, 2018 Date

State of Oregon, acting by and through its Oregon Health Authority
By:

Rhonda Busek Authorized Signature	Rhonda Busek Printed Name
Provider Services Director Title	2-20-18 Date

Approved for Legal Sufficiency:

Via email by Jeffrey J. Wahl Authorized Signature	*Jeffrey J. Wahl* Printed Name
Assistant Attorney General Title	*2/5/18* Date

OHA Program Review:

Chad D. Scott via email Authorized Signature	*Chad D. Scott* Printed Name
OHA Contract Administrator Title	*12/31/17 & 2/5/17* Date

ATTACHMENT 1:
Amendments to Exhibit A Part 2 – Statement of Work

EXHIBIT A

Part 2
Statement of Work

1. General provisions applicable to all Work.

a. Contractor shall require Contractor's paid and non-paid employees to treat Fee-for-Service (FFS) Clients with respect and due consideration for his or her dignity and privacy.

b. Contractor shall foster and promote preventive, community and primary healthcare, including mental and physical healthcare, which aims to keep FFS Clients active, healthy, and independent members of society.

c. Contractor shall allow the FFS Client to participate in decisions regarding their healthcare, including the right to refuse advice, Program participation, healthcare provider recommendations, and treatments.

d. Contractor shall, upon a FFS Client's request, provide information on the structure and operation of the Contractor's organization.

e. Contractor's Work will not include contracting with healthcare provider networks and Contractor will not be the payer of medical treatments or procedures rendered to the FFS Client.

2. Evidence-based Practices.

a. Contractor shall adopt evidence-based practice guidelines that are based on valid and reliable clinical evidence, or on a consensus of healthcare professionals, in consultation with Contractor's participating healthcare providers in the healthcare provider's particular field. Contractor's evidenced-based practice guidelines must consider the needs of FFS Clients.

b. Contractor shall periodically review, at least annually, and update, as appropriate, its evidence-based practice guidelines.

c. Contractor shall disseminate the evidence-based practice guidelines to healthcare providers of Clients enrolled in the Program, and, upon request, to OHA, FFS Clients, potential Clients, or Client representatives.

d. Contractor's decisions for utilization management, coverage of services, or other areas to which the guidelines apply, should be consistent with the adopted evidence-based practice guidelines.

e. Contractor shall describe in its annual written evaluation of its quality improvement program its process for adoption and dissemination of the evidence-based practice guidelines and identify those that have been adopted.

3. Care Coordination Services.

a. General Provisions for Care Coordination.

(1) Contractor shall provide a comprehensive, seamless, statewide program of Care Coordination services to FFS Clients with a focus on improving healthcare outcomes and eliminating access barriers.

(2) Contractor shall provide Care Coordination services to FFS Clients who meet eligibility criteria as adopted by OHA and described in this Contract. Contractor shall notify FFS Clients eligible for participation in Care Coordination of their potential enrollment in Contractor's Program as described in Section 9 Enrollment.

(3) Contractor shall provide Care Coordination services in accordance with the intent and objectives of OHA's Health System Transformation.

(4) Contractor shall operate its Care Coordination program in accordance with established federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

(5) Contractor shall provide Care Coordination services for FFS Clients with physical health needs, as well as mental health, dental health, behavioral health, long-term care service and support needs, and substance abuse issues.

(6) Contractor shall prioritize its Care Coordination on the identification, engagement, and improved outcomes of high risk, high acuity FFS Clients.

(7) Contractor and OHA shall cooperatively develop a plan to incorporate the Living Well with Chronic Conditions program into the options available to FFS Clients.

(8) Contractor and OHA will seek parallel opportunities for community and provider engagement statewide.

b. Person-Centered Care Coordination.

Contractor's person-centered, integrated Care Coordination shall:

(1) Use evidence-based practices, interventions (as specified in 3.i.(1) below), and strategies that objectively show improved health outcomes, reduce medical costs, and increase the FFS Client's ability to remain independent in Client's own residence or in a Home and Community-based Care services (HCBS) setting.

(2) Use health and social services resources that allow FFS Clients with disabilities to live independently at home or with others as long as medically appropriately and safe for the Client.

(3) Focus its Care Coordination program on improving FFS Client health outcomes and eliminating barriers to accessing healthcare services with emphasis on prevention.

(4) Use interventions and strategies that objectively show reductions in the progression of chronic conditions and decreasing acuity/occurrence of catastrophic medical events.

(5) Transition the FFS Client effectively through a continuum of coordinated care services and health care settings using cost-effective Care Coordination within the OHP Medicaid parameters.

(6) Collaborate and coordinate with OHA's Targeted Case Management programs, the Patient Centered Primary Care Homes, and the Coordinated Care Organizations to prevent duplication of efforts and assure FFS Clients' continuity of care between delivery systems.

(7) Focus on effecting the following outcomes:

(a) Improved FFS Client health and reduced medical costs.

(b) Improved access to Patient Centered Primary Care Homes.

(c) Improved access to healthcare services or Targeted Case Management.

(d) Reduced utilization of hospital emergency departments and hospital re-admissions.

(e) Reduced progression of chronic conditions and the acuity of catastrophic medical conditions.

(f) Improved utilization of behavioral health services provided in outpatient and licensed residential and inpatient settings.

(g) Decreased wait time for individuals waiting to be discharged from the Oregon State Hospital.

c. Care Coordination Health Stratification Process.

(1) Contractor shall use a mutually agreed upon health stratification process that assigns FFS Clients to unique care coordination categories based on clinical, functional, and social needs, patterns of risk for disease, and expected resource requirements.

(a) Contractor's health stratification process shall ensure the correct coordinated healthcare services are provided to FFS Clients.

(b) Contractor shall ensure that the FFS Clients are accurately identified and managed at the most appropriate level of intervention using a one through five acuity ranking and as defined by Contractor's risk stratification criteria and/or other mutually agreed upon acuity rankings.

(c) Contractor shall affirm FFS Client's clinical stratification and risk assessment as appropriate to the FFS Client's needs.

(d) Contractor's health stratification process must be based on an analysis of Medicaid claims using a predictive modeling process which assigns FFS Clients to unique, mutually-exclusive,

morbidity categories based on patterns of risk for disease and expected resource requirements.

(2) Contractor shall ensure Care Coordination services are provided to the FFS Clients identified through the health stratification process in subsection (1) above.

(3) Contractor shall ensure the type, frequency and intensity of FFS Client interventions are determined based on a health stratification process and acuity level Contractor establishes for FFS Client.

(4) In addition to Contractor's health stratification process, Contractor shall apply and utilize financial cost data for the past 12 months, co-morbidities for the past 12 months, multiple utilization patterns, and lack of ambulatory care within the past six months, as applicable.

(5) Contractor shall move the FFS Client between clinical stratification and risk assessment levels when indicated by the FFS Client's needs. FFS Client's movement between acuity levels and the final determination of acuity levels shall be based upon the following:

(a) The completed initial assessment;

(b) The clinical stratification and risk assessment process; and

(c) The registered nurse or primary care manager's determination during subsequent telephonic or in-person interventions.

d. Immediate Care Coordination.

Contractor may prioritize FFS Clients for immediate Care Coordination services when one of the following occurs:

(1) FFS Client is determined to be at risk through the daily health stratification and risk assessment process.

(2) Intervention algorithms, healthcare follow-up, or health assessments are obtained through the NAL.

(3) Health assessments conducted by Contractor's Care Coordination program staff identify the need for immediate Care Coordination services.

(4) Healthcare facility or clinic and community-based outreach efforts by Contractor.

(5) Real-time referrals from OHA, healthcare providers, or other health entities, agencies, or members of the FFS Client's family.

e. Care Coordination Eligibility. Contractor shall verify the FFS Client's eligibility, benefit package, service provider status, and funded service coverage for Care Coordination services. Contractor will use the Medicaid Management Information System (MMIS) to determine FFS Client's benefit package and coverage.

f. Care Coordination Initial Assessment.

(1) Contractor shall locate and attempt to contact all newly enrolled OHA FFS Clients. Contractor will outreach to high acuity (4-5) FFS Clients within 30 days after enrollment as a FFS Client and will outreach to moderate (1-3) acuity FFS Clients within 60 days after enrollment as a FFS Client.

(2) Contractor shall perform an initial assessment of all new FFS Clients identified by OHA within 90 days after the first successful attempt to contact the FFS Client. Contractor shall use the initial assessment to obtain an understanding of the FFS Client's risks, chronic conditions, or disease processes in order to develop individualized care management action plans, prioritize interventions, and plan Care Coordination follow-up. The FFS Client's initial assessment shall include:

(a) Diagnosis and medical history.

(b) The presence or absence of routine sources of care.

(c) Recent signs and symptoms associated with any identified chronic illnesses.

(d) Primary disease processes and co-morbidities.

(e) Current treating health professionals and medications.

(f) Any cultural factors about healthcare which influence access, receptivity, or service provider behavior.

(g) Risk for depression and substance abuse.

(3) Contractor shall provide health literacy assessments to measure the degree to which the FFS Client has the capacity to understand basic health information and services to make appropriate health decisions.

g. Contacts with Fee-for-Service Clients for Care Coordination.

(1) Contractor shall contact the FFS Client as frequently as required by the FFS Client's clinical and social service needs. Contractor shall ensure that frequency of contact and any interventions are prioritized regularly based on those needs and are aimed at the FFS Client's goal achievement and improved clinical outcomes.

(2) Prioritization of FFS Clients for in-person contact is based on claims, prior assessments, and other information available to Contractor that assists Contractor in determining the appropriate Care Coordination services.

(3) Initial contacts with the FFS Client for Care Coordination must be made by Contractor's care coordinator, a registered nurse or a primary care manager.

(4) Contractor shall, at each subsequent contact with the FFS Client, review assessments and assessed acuity level, diagnosis, and medical history and update the FFS Client's information and plan-of-care as indicated during the contact. Updates to the FFS Client's clinical information shall include assessments for behavioral and mental health problems that are clinically relevant in the judgment of the registered nurse or the clinician.

(5) Contractor shall follow up based on clinical discretion. Contractor shall adjust the frequency of the registered nurse or primary care manager's support for FFS Client as the FFS Client progresses toward meeting the goals developed and stated in the FFS Client's individual plan-of-care.

h. Plan-of-Care.

(1) Contractor shall prepare a plan-of-care for each assessed and engaged FFS Client and schedule regular follow-up with a registered nurse or primary care manager as part of Contractor's Care Coordination and as based upon the FFS Client's specific healthcare needs. Each FFS Client plan-of-care will be stored on Contractor's operating system.

(2) Contractor shall prepare the plan-of-care after Contractor's initial assessment with each FFS Client. The plan-of-care must address identified areas of risk for the FFS Client and include goals established with the FFS Client. The plan-of-care must support the ability of the FFS Client to be safely and effectively maintained in the setting of their choice and at the most efficient and effective level of care. The FFS Client's plan-of-care must support the FFS Client's Patient Centered Primary Care Home (PCPCH) whenever possible.

(3) A FFS Client's plan-of-care must include ongoing assessments of the FFS Client's health and:

(a) Instruction and support of the FFS Client's ability to practice self-management skills.

(b) Instruction and assistance in securing supportive resources.

(c) Education, information, and referrals for tobacco cessation and avoidance of second-hand smoke.

(d) Screenings for depression, behavioral and mental health considerations, alcohol and substance abuse, dementia and other most common co-morbid conditions as part of the clinical assessment.

(e) Education and assistance with the reduction or elimination of barriers to care.

(f) Assessment of the FFS Client's medication knowledge and compliance.

(g) Assessment of the FFS Client's receptivity to healthcare provider communications and instructions to improve the FFS Client's dialog with those providers.

(h) Education and information on the use of medical resources, such as emergency room services and crisis centers in support of the FFS Client's PCPCH.

(i) Provision of information about advance directives and determination of the presence or absence of advance directives.

(j) Assessment of the FFS Client's understanding of his or her individualized plan-of-care.

i. Care Coordination interventions.

Contractor's Care Coordination services must provide interventions based upon an assessment of the FFS Client's healthcare needs. The interventions must be consistent with evidence-based practices, clinical guidelines, and recommended treatments for the FFS Client's disease status, and be specific to the FFS Client's acuity level and need. Contractor shall ensure the type, frequency, and intensity of interventions are based on the risk and acuity level established for the FFS Client by the Contractor.

(1) Care Coordination interventions include the following:

(a) Assistance with coordination of resources, including medical needs and ancillary services.

(b) Assistance with medical appointments and in locating transportation services.

(c) Adjustments in living arrangements.

(d) Coordination and assistance in maintaining healthcare services and activities of daily living.

(e) Assistance with discharge and post-discharge planning:

i. Discharge planning from inpatient to nursing facility or home-based or community living;

ii. Discharge planning from nursing facility to home-based or community living.

(f) Coordination of FFS Client's benefits for a period of time appropriate to and dependent upon diagnosis and needs.

(g) Communication with FFS Client, healthcare providers, healthcare facilities, OHA, DHS-APD, and family or care givers about treatment needs and development of plans-of-care.

(h) Facilitating communication with healthcare service and clinical providers to address primary healthcare issues, clinical or social services alerts; to identify gaps in service or care; and to increase utilization related to FFS Client's assessed and self-reported needs.

(i) Coordination of referrals to appropriate groups for support, activity, recreation, social services, legal and financial counseling, and respite care.

(j) Assistance with eliminating barriers to healthcare with the goal of improved self-sufficiency.

(k) Education on healthcare practices needed for self-improvement and maintaining independence that is culturally and linguistically appropriate.

(2) Contractor shall prioritize the type of interventions on an ongoing basis aimed at achievement of Care Coordination goals and improved health outcomes.

j. Contractor shall track and monitor the FFS Client's progress and clinical outcomes toward the Client's identified clinical outcome objectives and goals.

k. Contractor shall support FFS Client placement in a PCPCH and shall assist OHA in finding PCPCHs for FFS Clients. Contractor shall encourage and promote the benefits of a PCPCH for FFS Clients.

l. Contractor shall collaborate and coordinate:

(1) with the PCPCH care teams to provide interventions, assistance, consultation, transition, and discharge;

(2) with inpatient, outpatient, long term services and supports, emergency departments; and

(3) with other care plan activities to promote and support the FFS Client in the PCPCH environment.

m. Contractor shall support the use of, and refer the FFS Client to, chronic disease self-management community-based programs, tobacco cessation services, and appropriate evidence-based prevention screenings and procedures. Contractor shall ensure referrals are condition, age, and gender appropriate for the FFS Client.

n. Contractor shall provide appropriate FFS Client referrals and follow-ups with dental health providers.

o. Contractor shall assist OHA and DHS-APD in the determination of appropriate Care Coordination services for activities of daily living, occupational therapy, physical therapy, private duty nursing, medication management, and post discharge transition of care.

4. Comprehensive Care Coordination.

a. Contractor shall provide professional, comprehensive, Care Coordination management to OHA.

b. Contractor shall consult with OHA when requested and shall make recommendations on Care Coordination for FFS Clients.

c. Contractor shall evaluate and provide input on current Care Coordination practices and identify improvement opportunities to benefit FFS Clients.

d. Contractor shall collaborate with OHA and other OHA contractors to develop and facilitate opportunities to meet mutual Care Coordination goals.

e. Contractor shall commence, no later than September 1st, 2016, Evaluations for Prior Authorization (PA) of Services for the FFS population as follows. Contractor is not required to complete out of state provider, transplant or out of hospital birth PA's. OHA will complete all work relevant to those PA types:

(1) Complete evaluations and PA's according to appropriate Oregon Administrative Rules (OAR).

(2) Complete evaluations and PA's in accordance with Health Evidence Review Commission's Prioritized List per OAR.

(3) Complete processing of PA's for the Electronic Document Management System's (EDMS) load time as follows:

(4) Immediate Requests will be completed within 24 hours of receipt. (Important: Emergency services do not require PA)

(5) Urgent Requests will be completed within 72 hours of receipt

(6) Routine Requests will be completed within 10 business days of receipt.

(7) Complete PAs using OHA's Medicaid Management Information System (MMIS) PA subsystem. Document decisions and clinical judgment within this system.

(8) Implement process for individual case referral from Utilization Management (UM) to Case Management (CM) for comprehensive care coordination of potential cases identified through PA requests.

(9) Work with OHA to develop necessary reports to share on file sharing system (see section 13) that will include at a minimum number of PA's received, type of PA, number approved, number pended, number denied, number of PA's handled by reviewer, and number referred for Medical Management review.

(10) Ensure that staff conducting PA evaluations have adequate knowledge of the Oregon Administrative Rules and Prioritized List of Health Services including amendments and changes that are routinely made.

~~e. Contractor shall commence, no later than September 1st, 2016, Evaluations for Prior Authorization (PA) of Services for the FFS population as follows. Contractor is not required to complete out of state provider, or transplant or out of hospital birth PA's. OHA will complete all work relevant to those PA types:~~

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~~**(a)** Immediate Requests will be completed within 24 hours of receipt. (Important: Emergency services do not require PA)~~

~~**(b)** Urgent Requests will be completed within 72 hours of receipt~~

~~**(c)** Routine Requests will be completed within 10 business days of receipt.~~

~~**(4)** Complete PA's using OHA's Medicaid Management Information System (MMIS) PA subsystem. Document decisions and clinical judgment within this system.~~

~~**(5)** Connect the Evaluation and Prior Authorization process to the acuity rating for FFS Clients served to ensure that services are clinically appropriate and timely (i.e. coordinated). This will function will provide Contractor with added information that can potentially improve the care coordination offered to the FFS population and ultimately improve member health outcomes.~~

~~**(6)** Work with OHA to develop necessary reports to share on file sharing system (see section 13) that will include at a minimum number of PA's received, type of PA, number approved, number pended, number denied, number of PA's handled by reviewer, and number referred for Medical Management review.~~

~~**(7)** Ensure that staff conducting PA evaluations have adequate knowledge of the Oregon Administrative Rules and Prioritized List of Health Services including amendments and changes that are routinely made.~~

~~**(8)** Document any impact that Contractor may have by MMIS system and EDMS system/staff issues. These issue will be handled collaboratively and resolution handled mutually.~~

5. Disease Management and Intensive Care Management Services.

a. General Provisions for Disease Management (DM) and Intensive Care Management (ICM).

(1) Contractor's coordination of DM and ICM shall:

(a) Integrate evolved and innovative person-centered coordinated care practices into a quality, comprehensive, delivery model.

(b) Focus on the FFS Client to meet Client's healthcare needs in a holistic and comprehensive approach.

(c) Take into account cultural, educational, social, mental, behavioral, and economic issues that affect the FFS Client's ability to manage their condition, illness, or disease.

(d) Connect FFS Clients to services that reduce the FFS Client's chances of catastrophic or severe illness or unnecessary utilization of costlier healthcare or levels of service.

(2) Contractor shall coordinate DM and ICM services for FFS Clients with complex health needs, as well as mental health, dental health, behavioral health, long-term service and support needs, and substance abuse issues.

(3) Contractor shall notify FFS Clients eligible for participation in DM or ICM of their potential enrollment in Contractor's Program as described in Section 9 Enrollment.

b. DM and ICM Stratification Process.

(1) Contractor's DM and ICM services shall be provided to FFS Clients who are identified as high risk, high acuity through the Contractor's health stratification and risk assessment processes.

(2) Stratification for DM and ICM services must be based on the Chronic Disease and Illness Payment System (CDPS) which assigns FFS Clients to unique, mutually-exclusive morbidity categories based on patterns of disease and expected healthcare resource requirements.

(3) Contractor will stratify or affirm FFS Clients' acuity stratification monthly.

c. DM and ICM Assessments.

Contractor's DM and ICM assessments specific to FFS Clients in high acuity, high risk may include the following:

(1) Review of waiver program benefits to determine the appropriateness of healthcare services.

(2) A transition of care assessment and medication management when indicated.

(3) An assessment of the understanding by the FFS Client and the Client's healthcare provider of the key elements of the necessary interventions and approach to care.

d. DM and ICM interventions.

Contractor shall provide face-to-face or in-person DM or ICM interventions to high risk, high acuity FFS Clients in the FFS Client's residence when:

(1) The registered nurse or primary care manager determines that the FFS Client cannot be effectively managed telephonically, or

(2) The registered nurse or primary care manager determines that the FFS Client's residence is the only environment DM or ICM interventions could be effectively provided; or

(3) Contractor is unable to utilize local, community, public health resources; or

(4) No other State funded registered nurse home-based care is being provided; or

(5) When directed by OHA or DHS-APD.

An exception may be made to providing face-to-face, in-person interventions in the FFS Client's residence when there is an imminent risk or threat to the safety of the FFS Client or the Program staff.

e. Disease Management Eligibility.

FFS Clients are eligible to receive Contractor's DM services when OHA eligibility criteria are met and through at least one of the following:

(1) The FFS Client's monthly health stratification and risk assessment process.

(2) The intervention algorithms, follow-up contacts, or assessments obtained through a NAL contact.

(3) The health assessments conducted by Contractor's healthcare staff.

(4) Contractor's outreach activities with healthcare facilities or clinic and community-based programs.

(5) Referrals to Contractor from OHA, healthcare providers, other healthcare entities or agencies, or the FFS Client's family members.

f. Disease Management.

(1) Contractor must stratify the FFS Client receiving DM services into one of three risk acuity levels: high (4-5), moderate (1-3) or low (0).

(2) Contractor shall ensure that the FFS Client accessing the DM services through the Contractor's Program is accurately identified as high, moderate or low acuity, as defined by the Chronic Disease and Illness Payment System (CDPS) stratification criteria.

g. Intensive Care Management Eligibility.

FFS Clients are eligible to receive Contractor's ICM services when OHA eligibility criteria are met and through at least one of the following:

(1) The FFS Client's monthly health stratification and risk assessment process.

(2) The intervention algorithms, follow-up contacts, or assessments obtained through a NAL contact.

(3) The health assessments conducted by Contractor's healthcare staff.

(4) Contractor's outreach activities with healthcare facilities or clinic and community-based programs.

(5) Referrals to Contractor from OHA, healthcare providers, other healthcare entities or agencies, or the FFS Client's family members.

h. Intensive Care Management.

(1) Contractor shall coordinate ICM services for FFS Clients including intervention services, physical and oral health services, behavioral health services, and children and youth services.

(2) Contractor shall coordinate with OHA and DHS-APD and affiliated agencies to increase awareness and utilization of existing ICM resources that would be beneficial to FFS Clients.

(3) Contractor shall coordinate with other community healthcare providers, including home health, cardiac rehabilitation, physical therapy, psychiatric

clinicians, and other medically related support services, to assist FFS Clients receiving ICM services to meet goals set in the FFS Client's plan-of-care.

(4) Contractor shall provide ICM services in the FFS Client's home or community as appropriate for the FFS Client.

(5) Contractor shall provide ICM services to FFS Clients identified as having immediate or emergent acute care or transition needs, frequent emergency department utilization or hospitalization, or co-morbid conditions that require complex medical care management services, to assist the FFS Client to cope with their acute condition.

(6) Contractor shall transition the FFS Client, who was previously in lower risk, lower acuity Care Coordination program, from the Contractor's ICM program back to the FFS Client's registered nurse or primary care manager for continued support.

i. DM and ICM Outcomes.

Contractor's program for DM and ICM shall make reasonable best efforts to:

(1) Reduce per Client healthcare costs and long term care and support costs by:

(a) Reducing hospitalization of ambulatory care sensitive conditions.

(b) Reducing non-emergent utilization of emergency departments.

(c) Reducing tobacco and chemical dependency.

(d) Reducing the number of under-immunized children and adults.

(e) Enhancing, supporting, and incorporating self-management skills and healthy lifestyles.

(2) Reduce barriers to care from both the FFS Client's and healthcare provider's perspective.

(3) Reduce need for long term skilled nursing facilities from forecasted projections.

(4) Increase in-home residency from forecasted projections.

(5) Maintain or improve health functioning of long-term services and support recipients.

(6) Maintain or improve health functioning of long-term psychiatric care recipients.

j. Contractor shall work collaboratively with OHA's Pharmacy Clinical Services Contractor to synergistically monitor pharmacy utilization and improve compliance, thus improving health outcomes.

k. Contractor shall work with OHA staff to identify subpopulations that require interventions targeted to reduce disparities and improve health outcomes or improve access to services. This includes access monitoring plans and

consultation and reporting to advise OHA and provide recommendations on how to solve issues identified.

6. Nurse Triage and Healthcare Advice Line.

a. General Provisions for the Nurse Triage and Healthcare Advice Line (NAL).

(1) Contractor's NAL services must include:

(a) Evidence-based resolution algorithms,

(b) Decision support,

(c) Language translation or interpreter services,

(d) Culturally sensitive triage and healthcare advice,

(e) Remote 911 report and hold capability,

(f) Screening for FFS Client eligibility and insurance plan or CCO enrollment, and

(g) Point-in-time direct call transfers.

(2) Contractor's NAL services shall not discriminate between FFS Clients or vary its NAL services for those FFS Clients receiving specific Care Coordination, Disease Management, or Intensive Care Management services.

b. Contractor shall provide the NAL for all FFS Clients. Contractor's NAL shall be a toll-free number that is available 24 hours per day, seven days per week, including holidays, and 365 days per calendar year.

(1) The Contractor's Oregon NAL hours of operation shall be 8:00 a.m. to 5:00 p.m. Pacific Time.

(2) The Contractor's alternative NAL hours of operation shall be 5:00 p.m. to 8:00 a.m. Pacific Time.

c. Contractor's personnel who answer triage and healthcare calls and manage clinical triage services shall be registered nurses or disease management coordinators with the same availability schedule as subsection b above. All clinical triage services must be managed by a registered nurse. The registered nurses or disease management coordinators who staff the NAL will answer all calls and ascertain the FFS Client's symptoms or condition and will follow approved triage algorithms when transferring and assigning the call.

d. Contractor shall have protocols to direct FFS Clients accessing the NAL for triage services and healthcare advice to the most appropriate level of service and type of care required for the FFS Client's symptoms or condition.

e. Contractor shall ensure that FFS Clients are transitioned to and followed by Contractor's Care Coordination staff resources to manage the FFS Client's healthcare. FFS Clients receiving DM or ICM services will be referred to and followed by Program staff previously assigned to the FFS Client.

f. Contractor shall have procedures for FFS Client follow-up to NAL services. Contractor's procedures must provide follow up Care Coordination services by

Contractor's staff within 72 hours of the initial NAL contact and interaction with the FFS Client. Contractor shall follow the referred or transferred FFS Client and shall maintain documentation of the result of the referral or transfer to indicate the progression to Care Coordination, Disease Management, or Intensive Care Management.

g. Contractor shall immediately contact the local police, fire, or medical rescue agency (911) to alert authorities when, in the opinion of the Contractor's NAL staff, there is a suspicion of domestic violence, elder abuse, or other abuse or emergent situations requiring emergency response.

h. Contractor shall have Process Improvement or Quality Control measures to demonstrate caller satisfaction with the NAL services as described in Section 12 Evaluation; Quality Control; and Process Improvement.

i. Contractor shall require any approved Subcontractors who are providing NAL services to adhere to the same standards as required of Contractor. Contractor shall obtain OHA approval of all subcontracted NAL services pursuant to Exhibit B paragraph 18. Contractor shall be responsible to monitor the Subcontractor's service levels for compliance to the standards established by OHA and Contractor.

j. Contractor's NAL services shall include educational information as appropriate for telephonic services and referrals to available sources of healthcare education and instruction.

k. Contractor shall prepare written monthly reports of all NAL interactions as described in Section 13 Data, Records, and Reports.

7. Independent and Qualified Agent Services.

a. Based upon the standards defined in this Contract, Contractor shall perform the duties of the Independent and Qualified Agent (IQA) **to determine service eligibility, perform needs based assessments, review participant service plans, prior authorize HCBS and fee for service services, conduct medical appropriateness reviews (utilization management) and perform transition management and planning for recipients determined ready to transition ~~between~~ among levels of care.** ~~for 1915(i) HCBS services provided to members receiving fee-for-service home-based habilitation, home-and community-based behavioral habilitation, and home-and community-based psychosocial rehabilitation for individuals with chronic mental illness that are billed under the Medicaid optional 1915 (i) State Plan Home-and Community Based Services benefit.~~

~~The parties agree to a phased implementation schedule for the IQA 1915(i) HCBS services. Effective dates for implementation are provided below.~~

~~**a.** General Provisions for the Independent and Qualified Agent Services.~~

~~(1) Contractor shall perform the duties of an IQA for the independent and unbiased review of 1915(i) HCBS services provided to OHP members receiving fee-for-service home based habilitation, home and community~~

~~based behavioral habilitation, and home and community based psychosocial rehabilitation for individuals with chronic mental illness.~~

~~(2) Contractor shall ensure the Work is performed by an individual whose credentials meet the requirements for a Qualified Mental Health Professional as defined in OAR 410-172-0600.~~

b. Unless otherwise specified, Contractor shall ensure work is performed by ~~a~~ ~~staff~~ an individual who is a Qualified Mental Health Professional (QMHP) meeting the following qualifications:

A Licensed Medical Practitioner;
A graduate degree in psychology, social work, or recreational, art, or music therapy;
A graduate degree in a behavioral science field;
A bachelor's degree in occupational therapy and licensed by the state of Oregon; or
A bachelor's degree in nursing and licensed by the State of Oregon.

~~Graduate degree in psychology; or~~
~~Bachelor's degree in nursing and be licensed by the State of Oregon; or~~
~~Graduate degree in social work; or~~
~~Graduate degree in a behavioral science field; or~~
~~Graduate degree in recreational, art, or music therapy; or~~
~~Bachelor's degree in occupational therapy and be licensed by the State of Oregon;~~

AND

Education and experience which demonstrates the competencies to identify precipitating events; gather histories of mental and physical disabilities, alcohol and drug use, past mental health services and criminal justice contacts; assess family, social and work relationships; conduct a mental status examination; ~~document a multi-axial DSM diagnosis;~~ write and supervise a treatment plan, conduct a comprehensive mental health assessment; and provide individual, family, and/or group therapy within the scope of practice.

Contractor shall utilize accredited~~,~~ and/or evidence based, and generally accepted decision support criteria when performing prospective, concurrent and retrospective review activities.

b. ~~Eligibility Determination services shall be effective July 1, 2016.~~

~~Contractor shall conduct an evaluation or re-evaluation to determine if a recipient of 1915(i) HCBS services is eligible for the services based on the diagnostic and needs-based criteria defined in Oregon's 1915(i) State Plan Amendment. For purposes of this Work, recipient is an OHP member receiving home or community-based services whether they are FFS Clients, or are enrolled in a CCO and are also receiving FFS services ("Recipient").~~

~~(1) Contractor shall receive requests for eligibility determinations ("Referrals") for individuals who are potentially eligible for 1915(i) HCBS services from a referrer. Contractor shall provide technical assistance to the referrer about the eligibility determination process.~~

~~(2) Contractor shall develop an electronic database to track the receipt, content, and outcome of the Referral. Contractor shall electronically archive the Referrals and the clinical documentation accompanying each request. Contractor shall provide OHA access to the archived documentation.~~

~~(3) Contractor shall develop a website for use by individuals and providers seeking information on making a Referral or getting 1915(i) HCBS services. Contractor shall include relevant information, links, forms and contact information. OHA shall have the right to review and approve content of the website and to retain ownership upon expiration or termination of this Contract.~~

~~(4) Contractor shall develop communication materials that describe the Referral, eligibility determination, and independent assessment processes.~~

~~(5) Contractor shall determine whether the Recipient meets the following eligibility requirements:~~

~~(a) Have been diagnosed with a chronic mental illness as defined in ORS 426.495; and~~

~~(b) Have an assessed need consistent with the current or proposed level of care, due to a chronic mental illness.~~

~~(6) Contractor shall assess the Recipient's support needs through a review of the clinical documentation provided by the referrer, including:~~

~~(a) A behavioral health assessment meeting the requirements of OAR 309-019-0135 that has been developed within the last 12 months prior to submission and is signed by a Qualified Mental Health Professional.~~

~~(b) A treatment plan or plan of care, meeting the requirements in OAR 309-019-0140, that has been developed within the last 12 months of the eligibility determination and is signed by a Qualified Mental Health Professional.~~

~~(c) Recent progress notes supporting need for the 1915(i) HCBS services.~~

(d) Any additional clinical information supporting medical justification for the 1915(i) HCBS services requested.

(7) Contractor shall complete the eligibility determination review within three business days of receiving the Referral. Contractor shall complete urgent requests for an eligibility determination within 48 hours of receiving the completed Referral.

(8) Contractor shall provide written notification of the eligibility determination outcome to the referrer within three business days of a decision. If not eligible, Contractor shall provide an explanation of the decision and information on how to request reconsideration or to appeal the decision. Contractor shall include instructions on next steps.

(9) Contractor shall conduct eligibility redeterminations at least every 12 months for each Recipient using the standards defined in this Contract.

(10) Contractor shall conclude eligibility redeterminations within three business days of any request for redetermination.

(11) Contractor shall conduct internal quality and process reviews of eligibility determinations to ensure the level of scrutiny is consistent and monitored; including review of the original determination and any redeterminations using new information provided by the referrer.

(12) Contractor shall refer requests for appeal of the eligibility determination to OHA. OHA manages the appeal process and notifies the requester of the outcome of the appeal. OHA has the final determination of eligibility under the appeal process described in Oregon Administrative Rule.

(13) Contractor shall collect and report data for the 1915(i) quality assurance report. Data must be reported quarterly and shall include:

(a) Total number of evaluations conducted during the quarter.
(b) Total number of evaluations that meet HCBS eligibility criteria during the quarter.
(c) Total number of evaluations that were appealed.
(d) Total number of participants due for an annual redetermination.
(e) Total number of service plans that were adequate and appropriate to assessed need.
(f) Total number of service plans that address participants' personal goals,
(g) Total number of service plans that meet requirements of appropriate staff.
(h) Total number of service plans that reflect involvement of participant.
(i) Total number of service plans that include measurable and observable intended outcomes.
(j) Total number of service plans that were reviewed and revised based on changing needs.

~~(k) Total number of service plans that were revised within 12 months of their last evaluation when services continued for more than 12 months.~~

~~(l) Percent of participants records who received the type, scope, amount, duration and frequency of services specified in the service plan.~~

~~(m) Total number of records reviewed that demonstrated participant involvement in service plan development.~~

c. 1915(i) Eligibility Determination and Re-determination

(1) General Provisions of 1915(i) Eligibility Determination and Re-determination

(a) Contractor shall evaluate whether individuals meet needs-based eligibility using the process and criteria described in Oregon's 1915(i) HCBS state plan option.

(b) Contractor conducts a face-to-face independent functional needs assessment of individuals determined to be eligible for the 1915(i) HCBS State Plan Option benefit. The needs assessment meets federal requirements at 42 CFR §441.720.

(c) Contractor shall conduct a face-to-face reassessment of individuals' functional needs at least every 12 months, as needed when the individual's circumstances or needs change significantly, and at the request of the individual as required under 42 CFR §441.720(b).

(d) Based on the independent functional needs assessment, contractor shall develop a person-centered service plan for each individual determined to be eligible for the 1915(i) HCBS State Plan Option. Contractor shall develop the person-centered service plan using a person-centered service planning process in accordance with 42 CFR §441.725(a), and the resulting written person-centered service plan meets federal requirements at 42 CFR §441.725(b).

(e) Contractor shall review and revise the person-centered service plan upon reassessment of functional need as required under 42 CFR §441.720, at least every 12 months, when the individual's circumstances or needs change significantly, and at the request of the individual.

(f) Contractor shall develop an electronic database to track the receipt, content, and outcome of the Referral. Contractor shall electronically archive the Referrals and the clinical documentation accompanying each request. Contractor shall provide OHA access to the archived documentation.

(g) Contractor shall develop a website for use by individuals and providers seeking information on making a Referral or getting 1915(i) HCBS services. Contractor shall include relevant information, links, forms and contact information. OHA shall have the right to review

and approve content of the website and to retain ownership upon expiration or termination of this Contract.

(h) Contractor shall develop communication materials that describe the Referral, eligibility determination, and independent assessment processes.

(i) Contractor shall determine whether the Recipient meets the following eligibility requirements using the criteria and process described in the most current CMS-approved 1915(i) HCBS State Plan Option as follows;

(2) Process

(a) Contractor receives requests for eligibility determinations for individuals who are potentially eligible for 1915(i) HCBS from a referrer.

(b) Contractor works with the person and/or ~~their~~ his/her representative to establish a time to engage with the person in ~~their~~ his/her current location or a location of the person's choosing. When establishing an initial meeting, the IQA case manager will inform the person of his/her choice to include others that may have information about his/her needs or people who are important to and provide support for the individual.

(c) Contractor shall provide necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.

(d) Contractor conducts a face to face needs assessment with the individual, the individual's authorized representative, if applicable, and in consultation with other persons identified by the individual to determine if the individual is eligible based on the diagnostic and needs based criteria defined in the 1915(i) State Plan Option.

(e) Contractor performs needs based assessment through review of necessary clinical information, consultation with the individual, ~~individuals~~ individual's authorized representative and other persons important to the individual or who have knowledge of the ~~individuals~~ individual's service and support needs.

(f) As part of the person centered needs assessment process, contractor uses the Level of Care Utilization System (LOCUS) and the Level of Service Inventory (LSI) as part of the overall package of information used to determine whether an individual meets the needs based criteria for 1915(i) HCBS State Plan Option.

Contractor may suggest use of a different standardized assessment as part of the person centered plan and upon OHA/CMS approval, may use an assessment tool other than LOCUS or LSI.

(g) If it is determined the person is not eligible based on the needs based criteria, contractor shall notify the person and his/her representative in writing within three business days.

(h) If it is determined the person is eligible for 1915(i) HCBS, contractor shall conduct a person centered plan to document the person's needs and choices.

(i) Contractor shall make reasonable effort to connect with the individual to develop a person centered plan. Inability and/or lack of response from the individual will be appropriately documented.

(3) Person Centered Service Plan

(a) Person Centered Service Planning General Requirements

During the initial interaction to develop the person centered plan, Contractor shall provide information to the person (and/or those individuals chosen by the person) regarding eligibility and referral processes, available benefits, resources, services and supports covered under the 1915(i) HCBS.

Information shall be provided by Contractor verbally and in writing in a manner and language easily understood by the person and others the person has chosen to participate in the person centered assessment and planning process. Contractor shall develop print and online information about home and community based services and supports that includes information about providers~~,~~ and services and how to access them.

Through the person centered assessment and planning process, Contractor shall assist the person to identify the services, supports and benefits to assist him/her to achieve the goals or outcomes the person has identified as important. During this process, Contractor shall provide education, instruction and information about the person-centered assessment and planning process, and how it is applied, the range and scope of individual choices and options, the process for changing the person-centered service plan, grievance and appeals process, individual rights, risks and responsibilities of self-direction, free choice of providers and service delivery models, reassessment and review schedules, defining goals, needs and preferences, identifying and accessing services, supports and resources, development of risk management agreements, and recognizing and reporting critical events, including abuse investigations.

(b) Standards for Person-centered Planning services shall be implemented as required to serve the individual.

For each individual determined eligible for 1915(i) services, Contractor shall develop a person-centered plan of care that reflects the services and supports, and the delivery of such services and supports, which are important to the individual. The individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the individual are included in the planning.

Contractor shall prepare the written plan of care commensurate with the individual's level of need and the scope of the services and supports available that reflects the individual's strengths and preferences and includes individually identified goals and desired outcomes.

Contractor shall describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.

Contractor shall include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies. Contractor shall document and justify any modification that supports a specific and individualized assessed need.

Contractor shall make a copy of the Plan available to the person, the person's personal representative, the person's care coordinator and any applicable providers of HCBS services.

(c) Process requirements

Contractor shall complete the face to face eligibility determination review within three business days of receiving the Referral. Contractor shall complete urgent requests for an eligibility determination within 48 hours not to exceed two business days of receiving the completed Referral.

Contractor shall provide written notification of the eligibility determination outcome to the referrer within three business days of a decision. If not eligible, Contractor shall provide an explanation of the decision and information on how to request reconsideration or to appeal the decision. Contractor shall include instructions on next steps.

Contractor shall conduct eligibility redeterminations at least every 12 months for each ~~Recipient~~ individual using the standards defined in this Contract.

Contractor shall ~~conclude~~ complete eligibility redeterminations within the same time frames as noted above for initial determinations.

Contractor shall conduct internal quality and process reviews of eligibility determinations to ensure the level of scrutiny is consistent and monitored; including review of the original determination and any redeterminations using new information provided by the referrer.

Contractor shall refer requests for appeal of the eligibility determination to OHA. OHA manages the appeal process and notifies the requester of the outcome of the appeal. OHA has the final determination of eligibility under the appeal process described in Oregon Administrative Rule.

Contractor shall collect and report data for the 1915(i) quality assurance report. Data must be reported quarterly and shall include:

(a) Total number of evaluations conducted during the quarter.
(b) Total number of evaluations that meet HCBS eligibility criteria during the quarter.
(c) Total number of evaluations that were appealed.
(d) Total number of participants due for an annual redetermination.
(e) Total number of service plans that were adequate and appropriate to assessed need.
(f) Total number of service plans that address participants' personal goals,
(g) Total number of service plans that meet requirements of appropriate staff.
(h) Total number of service plans that reflect involvement of participant.
(i) Total number of service plans that include measurable and observable intended outcomes.
(j) Total number of service plans that were reviewed and revised based on changing needs.
(k) Total number of service plans that were revised within 12 months of their last evaluation when services continued for more than 12 months.
(l) Percent of participants records who received the type, scope, amount, duration and frequency of services specified in the service plan.
(m) Total number of records reviewed that demonstrated participant involvement in service plan development.

~~c.~~**d.** Medical Appropriateness Review services shall be effective July 1, 2016.

Contractor shall conduct Medical Appropriateness Reviews to ensure the level of care and the type of service provided to Recipients of fee-for-service **and OHA funded** behavioral health services~~, 1915(i) HCBS services and secure residential treatments~~ are medically appropriate **as described in OAR 410-172-0600 through 410-172-0860.**

Medical appropriateness reviews requiring prior authorization shall be completed in accordance with the requirements described in exhibit A, Part 2, Section 4, subsection e.

Medical appropriateness reviews for referral to, admission and continued stay in Secure Residential Treatment shall be made in accordance with level of care criteria for SRTF provided by OHA.

~~(1) Quality Assurance. Contractor shall complete a quality assurance review on each service authorization request to ensure the required documentation has been submitted and the documentation meets or exceeds requirements defined in OAR 410-172-0610 OAR 410-172-0650 and OAR 410-172-0720.~~

~~(2) Utilization Reviews. Contractor's qualified mental health professional will complete a clinical review using the standards for medical appropriateness as defined in OAR 410-172-0630.~~

~~(a) For rehabilitative mental health services, a utilization review will be completed by a qualified mental health professional based on the standards defined in 410-172-0650.~~

~~(b) For residential treatment, a utilization review will be completed by a qualified mental health professional based on the standards for prior authorization and reauthorization as defined in 410-172-0720.~~

~~(3) Contractor's utilization management shall prioritize review of services as follows:~~

~~(a) High cost services utilizing rates not included on the fee schedule;~~
~~(b) Services provided in secure residential treatment programs;~~
~~(c) Services with high utilization and low access for other members;~~
~~(d) Services associated with a high number of grievances or complaints;~~
~~(e) Services of the same type, intensity and frequency provided to members for 360 days or more without a break in service.~~

~~(4) Standards for Medical Appropriateness Reviews. Contractor shall complete the Medical Appropriateness Reviews based on the following standards.~~

~~(a) Standard 1: Receipt and Tracking of Prior Authorization Request.~~

~~A qualified professional will receive prior authorization requests by checking the fax, mail and e-mail daily. On a prior authorization request is received, the authorization is:~~

~~i. Date stamped,~~
~~ii. Logged into the authorization request database, and~~
~~iii. Organized in the following order (when included in request): Cover sheet on top (OHA 8060 or 8069); LSI; LOCUS; Assessment; Treatment Plan; and Progress Notes.~~

~~Once complete, the prior authorization request is electronically archived and labeled.~~

~~(b) Standard 2: Quality Assurance Review.~~

~~Upon receipt of a prior authorization request, a qualified mental health professional will review the documentation for completeness. A complete prior authorization will include:~~

~~i. A cover sheet (OHA 8060 or OHA 8069) completed fully and accurately and signed by an authorized representative of the agency.~~
~~ii. A behavioral health assessment and service plan meeting the requirements described in OAR 309-019-0135 through 309-019-0140 completed and dated within one year of the authorization request and signed by a QMHP or higher.~~
~~iii. A Level of Care Utilization System completed within 180 days of the request.~~
~~iv. A Level of Service Inventory completed within 30 days of the request.~~
~~v. Additional supporting clinical information supporting medical justification for the services requested.~~
~~vi. If the request is incomplete or the documentation does not meet the standards defined in rule, reviewer will contact the requestor and request the missing or incomplete documentation.~~
~~vii. The reviewer will contact the requestor either by phone, email or mail.~~
~~viii. The requestor has 10 business days to respond with requested information or reviewer will consider the request cancelled and destroy the request.~~
~~ix. This process should be completed with 10 business days of receiving the request.~~
~~x. Once complete, the request is given to the utilization reviewer.~~

~~(c) Standard 3: Utilization Review.~~

~~Upon completion of a quality assurance review, a qualified mental health professional will review the request for the following:~~

~~i. Medical Appropriateness:~~

A. Rendered by a provider whose training, credentials, or license is appropriate to treat the identified condition and deliver the service;

B. Based on the standards of evidence-based practice, and the services provided are appropriate and consistent with the diagnosis identified in the behavioral health assessment;

C. Provided in accordance with an individualized service plan and appropriate to achieve the specific and measurable goals identified in the service plan;

D. Not provided solely for the convenience of the Recipient, the Recipient's family, or the provider of the services or supplies;

E. Not provided solely for recreational purposes;

F. Not provided solely for research and data collection;

G. Not provided solely for the purpose of fulfilling a legal requirement placed on the Recipient.

ii. For residential services, the request will be reviewed for the following:

A. The appropriateness of the recommended length of stay;

B. The appropriateness of the recommended plan of care;

C. The appropriateness of the licensed setting selected for service delivery;

D. A level of care determination was appropriately documented.

iii. Re-authorization of services will be based on the Recipient continuing to meet all basic elements of medical appropriateness and one of the following criteria is met:

A. Documentation that the treatment provided is resulting in measurable clinical outcomes but that the Recipient is not sufficiently stabilized or yet developed the skills necessary to support transition to a less restrictive level of care;

B. The Recipient has developed new or worsening symptoms or behaviors that require continued stay in the current level of care;

C. Requests for re-authorization based on these criteria shall include documentation of ongoing re-assessment and necessary modification to the current treatment plan or residential plan of care.

~~This process should be completed with 10 business days of receiving request. Once complete, the completed review is given to the MMIS technical staff.~~

~~(d) Standard 4: Service Authorization entry into MMIS.~~

~~i. Completed requests are entered into either the plan-of-care or the prior authorization panel using the instructions in the appropriate OHA desk manual.~~

~~ii. Authorizations are entered as indicated on the OHA 8060 or OHA 8069.~~

~~iii. Denials are entered into MMIS using the corresponding denial code provided to Contractor.~~

~~iv. Contractor shall enter MMIS service authorizations accurately with less than a 5% rate of error.~~

~~v. All authorizations or denials will result in a service authorization notice being issued to the provider through MMIS.~~

~~vi. . All authorizations or denials will result in a notice of appeal rights being sent to the member via the MMIS.~~

~~(5) For each Medical Appropriateness Review invoiced to OHA, there must be an MMIS service authorization or denial entered accurately into MMIS. Accuracy is measured by the provider's ability to successfully submit a claim for rendering authorized services. OHA will not issue payment for these services until this condition is met.~~

~~d.~~ **e.** Conflict Free Case Management services shall be effective October 1, 2016.

(1) Contractor shall provide conflict free case management for the following member populations:

(a) Medicaid eligible individuals who are fee-for-service and who need assistance accessing behavioral health services.

(b) Individuals residing at Oregon State Hospital (OSH) who have been determined as ready to transition.

(c) Fee-for-service members who are currently residing in an OHA funded licensed level of care and have been determined to no longer need that setting in order to receive services and supports.

(2) Contractor shall perform the functions of conflict free case management for the following purposes:

(a) Service and Support Planning. Contractor shall engage in processes that lead to a service or support plan. Under CMS rules, these processes must be consistent with the person-centered approach and must include an independent needs assessment resulting in a documented plan of care. The plans-of-care for individuals residing at Oregon State Hospital, who have been

determined as ready to transition, shall be referred to as the hospital-to-community transition plans and must include a level of care recommendation. The plans-of-care for fee-for-service members, who are currently residing in an OHA funded licensed level of care and have been determined to no longer need that setting in order to receive services and supports, shall be referred to as the community transition plan.

(b) Monitoring. Contractor shall engage in processes for ensuring that services are delivered in according to guidance included in the support plan (hospital-to-community transition plan or community transition plan). Activities may include coordinating services, monitoring the quality of services, monitoring the participant, and reporting compliance of contracted entities responsible for implementing the support plan.

(c) Supporting services to be provided in the most integrated setting appropriate to the needs of the individual.

(d) For member populations residing at the Oregon State Hospital, or in secure residential treatment programs, Contractor shall achieve the performance metrics described in Exhibit F, Attachment 4 – IQA Rates and Metric and Performance Tables.

(3) Standard for Completed Work. For each person transitioned from OSH or a licensed level of care, a hospital-to-community transition plan or a community transition plan, in the form of a written person-centered services and supports plan, will be developed by the Contractor.

(4) The plan-of-care will be provided to the contracted community entity responsible for the coordination of care for the person prior to transition, considerate of the time necessary to implement the plan.

(5) Contractor's transition plans may include referral to licensed levels of care, recommendations for non-Medicaid services and supports, or the need for specialized services or funding.

(6) Contractor shall coordinate the implementation of the plan-of-care for individuals who do not have support or assistance from a community organization.

(7) Contractor shall provide technical assistance, monitoring and reporting to OHA regarding hospital-to-community transition plan implementation and outcomes.

~~**e.** Standards for Person-centered Planning services shall be implemented as required to serve the Recipients.~~

~~(1) Contractor shall develop a person-centered plan of care that reflects the services and supports, and the delivery of such services and supports, which are important to the Recipient. Recipient directs the process to the maximum extent possible and is enabled to make informed choices and decisions. Persons chosen by the Recipient are included in the planning.~~

~~(2) Contractor shall provide necessary information in plain language in a manner accessible to individuals with disabilities and persons whose English proficiency is limited. Cultural factors must be considered.~~

~~(3) Contractor shall prepare the written plan of care commensurate with the Recipient's level of need and the scope of the services and supports available that reflects the Recipient's strengths and preferences and includes individually identified goals and desired outcomes.~~

~~(4) Contractor shall describe any clinical and support needs identified through a functional needs assessment and indicate the paid and unpaid services and supports and the providers responsible for implementation.~~

~~(5) Contractor shall include risk factors and measures to minimize the risk factors, such as individualized backup plans and strategies.~~

~~(6) Contractor shall document and justify any modification that supports a specific and individualized assessed need.~~

~~(7) Contractor shall ensure staff conducting the independent assessments are trained in the use of standardized assessment tools selected by OHA. OHA has designated the use of the Level of Care Utilization System (LOCUS) and the Level of Service Inventory (LSI) for residential treatment to fulfill the requirements for independent assessment tools.~~

f. Treatment Episode Monitoring shall be implemented as required to serve the Recipients.

(1) **For OHA funded, fee for service and/or 1915(i) HCBS individuals authorized by the Contractor,** Contractor will conduct self-defined periodic review of approved services to determine the authorized service is provided in accordance with applicable Oregon Administrative Rules and the service meets the criteria for quality and medical appropriateness.

(2) **For OHA funded, fee for service and/or 1915(i) HCBS individuals authorized by the Contractor,** Contractor shall determine type and frequency of review based on the type of service and authorization parameters. Reviews shall be conducted through onsite visit, face to face interview of Recipient or provider, document review, clinical documentation review or data analysis.

(3) Treatment episode monitoring may include administration or review of **standardized assessments or tools determined by the contractor.** ~~the Level of Care Utilization System and / or the Level of Service Inventory or other assessment or tool determined by Contractor.~~

Concurrent review of need for inpatient care.

- **For recipient groups to be determined by OHA, contractor shall provide prospective and/or concurrent review by a physician, physician assistant, or nurse practitioner for the purpose of ensuring the medical appropriateness of inpatient services funded by OHA or for which Oregon claims federal medical assistance payments. Certification must be provided by a physician, ~~or~~ physician assistant or nurse practitioner acting within the scope of practice as defined by State law.**
- **~~Member~~ Recipient groups and initial review and periods of authorization and re-review will be based on OHA's business or regulatory needs.**
- **Certification and re-certification shall be based upon**
- **Proper treatment of the psychiatric condition requires services on an inpatient basis under the direction of a physician; and**
- **The services can reasonably be expected to improve the individual's condition or prevent further regression so that the services will no longer be needed.**
- **For individuals with SPMI at OSH under civil commitment or voluntary by guardian:**
    - **for more than 90 days, the contractor shall perform a clinical review of the individual's status to determine whether a continued stay at OSH is necessary.**
        - **When a review is performed, the justification for the individual's stay shall be clearly documented.**
        - **If the contractor determines that there is an appropriate clinical justification for the individual to remain at OSH, the contractor shall approve the extension of the individual's stay for up to 45 additional days.**
            - **If an extension has been approved, the contractor shall conduct a follow-up clinical review of the individual's status every additional 45 days.**
        - **If the contractor determines that there is not an appropriate clinical justification for the individual to remain at OSH, contractor shall immediately notify OSH of the determination.**

(4) For each treatment episode monitoring service invoiced to OHA, Contractor shall provide OHA a treatment episode monitoring detail report describing the reason for the review, the type of review, and the outcome of the review. OHA will not issue payment for these services until this condition is met.

g. Census Reporting shall be effective October 1, 2016.

Contractor shall develop and provide an ongoing accessible report containing information about fee-for-service members currently in a licensed level of care, including:

(1) Member name,
(2) Member Medicaid number,
(3) Member age,
(4) Primary diagnosis,
(5) County of responsibility,
(6) Referral source, such as OSH, acute care, post-acute intermediate treatment, licensed care, or the community,
(7) Managed care enrollment status (Enrolled or FFS),
(8) Level of care (AFH, RTF etc.),
(9) First or previous ~~LOCUS / LSI, or Contractor determined~~ assessment score,
(10) Second or previous ~~LOCUS / LSI, or Contractor determined~~ assessment score,
(11) Current ~~LOCUS / LSI, or contractor determined~~ assessment score,
(12) Name of current provider,
(13) Date of admission,
(14) Length of stay for current treatment episode,
(15) Whether i-plan eligible (Y/N), and
(16) Expiration of i-plan eligibility.

OHA must be able to access a report containing the required information listed above. The information will be accurate to the information provided to Contractor. OHA will not issue payment for these services until this condition is met.

h. The Independent and Qualified Agency rates and metrics and performance expectations are contained in Exhibit F, Attachment 4 – IQA Rates and Metric and Performance Tables.

8. Outreach and Engagement.

a. Contractor shall contact all new high risk, high acuity and moderate risk, moderate acuity FFS Clients within 30 calendar days of receipt of the monthly claims data from OHA. This 30-day outreach requirement must include FFS Clients who stratify as acuity levels of four or five.

b. Contractor shall contact all new FFS Clients with lower risk and acuity within 60 calendar days of receipt of the monthly claims data from OHA. This 60-day outreach requirement must include FFS Clients who stratify as acuity levels of one, two, or three.

c. Contractor shall document, in Contractor's FFS Client Management System, new FFS Clients, who have been successfully contacted by the Contractor and who consent to participate in the Program and to receive Program services. A successful contact, or engagement, may be accomplished when the Contractor

makes telephone contact with the FFS Client and the FFS Client orally agrees to receive Program services.

d. Contractor shall attempt to contact the FFS Client by telephone on three separate days and times over the applicable 30-day or 60-day required period as described in subsections a. and b. above. If the three telephone attempts are unsuccessful, Contractor shall attempt to engage the FFS Client using alternative outreach methods, such as mailing a request for the FFS Client to contact Contractor, or contacting the FFS Client in person or face-to-face.

e. Contractor shall have a process to document its attempts to contact the FFS Client, any follow-up attempts, and the results of the attempts. Contractor shall use this documentation to determine the most successful methods to engage FFS Clients and to recommend changes to OHA.

f. Contractor shall not make further attempts to engage a FFS Client:

(1) Who fails to respond to the telephone and other contact attempts as described in subsection d. above.

(2) Whose mail is returned "unable to deliver" with no forwarding information.

(3) Who does not meet the criteria for an acuity score as determined by Contractor's health stratification and risk assessment processes.

(4) Who has opted-out of the Contractor's Program for Care Coordination and other services.

(5) Who, when contacted, is determined to be not eligible for Contractor's Program.

g. Notwithstanding subsection f. above, Contractor shall attempt to locate and engage FFS Clients in person in healthcare provider offices, clinics, hospitals, or other community locations:

(1) When the Program eligible FFS Client remains within the high risk, high acuity level or at risk for utilization for greater than 90 calendar days and has failed to respond to other contact attempts.

(2) When the Program eligible FFS Client remains within the high risk, high acuity level or at risk for utilization for greater than 90 days and has no active telephone number on file.

h. Contractor shall suspend FFS Clients from its client engagement process when all attempts to contact and locate the FFS Client as described in this Section have been unsuccessful. Contractor shall document in its FFS Client Management System those FFS Clients suspended from its client engagement process. Contractor shall continue to provide NAL services to FFS Clients who have been suspended from its client engagement process. Contractor shall not deny FFS Clients future enrollment in the Program due to a suspension of the engagement process.

i. FFS Clients may opt-out of the Contractor's Program during the engagement process. FFS Clients who opt-out of the Program and remain on OHP fee-for-

service status may receive Oregon Health Plan Care Coordination (OHPCC) services at any time.

j. Outreach Communications.

Contractor shall ensure all outreach communications with FFS Clients:

(1) Are culturally and linguistically appropriate;

(2) Are provided in a manner or format easily understood by FFS Client;

(3) Indicate the toll-free telephone number for Contractor's Program of healthcare services; and

(4) Include the Contractor's Program name, contact information, and web-site address.

k. Outreach for Program Enrolled FFS Clients.

(1) Initial Outreach Package.

(a) Contractor shall provide an initiation or initial welcome outreach package to all FFS Clients newly enrolled in Contractor's Program. Contractor's outreach package must, at a minimum:

i. Include information about the FFS Client's enrollment in the Program.

ii. Inform the FFS Client that enrollment is part of the Client's Medicaid benefit and that the Program is provided at no cost to Client.

iii. Introduce the Program services available to the FFS Client.

iv. Include information about Care Coordination, Disease Management and Intensive Care Management, and the NAL.

v. Include a copy of the Client's Rights and Responsibilities as described in Exhibit F of this Contract.

vi. Notify the FFS Client that participation in the Program is by choice and that the FFS Client retains the right to opt out of the Program at any time.

Contractor will provide the initial welcome outreach package to the Program enrolled Clients within 30 calendar days of notification of the Client's enrollment.

(2) Contractor shall include ongoing education and instruction in its outreach to FFS Clients. Contractor's education and instruction shall include the following topics:

(a) Self-care skills and assistance with securing supportive resources.

(b) Education and coaching on tobacco cessation and avoidance of second hand smoke.

(c) Education and assistance on the elimination of barriers to care.

(d) Education and coaching on the use of medical and community resources, in support of a PCPCH and the FFS Client's health conditions.

(e) Education and coaching about medication management.

l. Contractor shall schedule regular visits to high volume or high utilization Medicaid fee-for-service hospitals and emergency departments and federally qualified health centers, with a goal of minimizing inappropriate FFS Client visits and reducing both admissions for the same condition and lengths of stays.

m. Contractor shall work with healthcare providers, stakeholder groups, OHA and DHS-APD to promote participation and enrollment in Contractor's Program and to maximize knowledge and utilization of existing resources.

(1) Contractor shall establish working relationships, partnerships, or collaborations with other OHA divisions, other State agencies, and profit and non-profit organizations as these relationships, partnerships, or collaborations relate to FFS Clients.

(2) Contractor shall support the activities of other OHA divisions, other State agencies, and profit and non-profit organizations as the activities relate to FFS Clients.

(3) Contractor shall incorporate into its Program access or referral to, or utilization of, existing resources available from other OHA divisions, State agencies, or profit and non-profit organizations when appropriate to the Program and to the benefit of FFS Clients.

(4) Contractor shall facilitate communication to address primary healthcare issues, clinical or social services alerts, identified gaps in care, and increased utilization related to FFS Clients' assessed and self-reported needs.

(5) In collaboration with OHA, Contractor shall utilize OHA's Pharmacy Clinical Services contractor for consultation in the areas of Drug Use Review, Preferred Drug List development and maintenance, drug use policy and evaluation of drug therapy.

n. Contractor shall maintain a Clinical Advisory Committee (CAC). The purpose of the CAC is to establish an ongoing positive relationship with the healthcare community and to maintain a consistently high-level of communication with stakeholders. The CAC shall consist of key stakeholders, chosen by Contractor and approved by OHA, that meets twice per calendar year, or as mutually agreed upon by the Contractor and OHA. OHA shall provide a representative for the CAC who shall participate as a stakeholder on the committee.

9. Enrollment.

a. FFS Clients enrolled in the OHP, who are included within the eligibility files received by Contractor from OHA, are eligible for enrollment in the Contractor's Program and for Contractor's services. Clients may enroll in Contractor's Program either by telephone or mail correspondence or in person agreement as described in this Contract. Participation in the Contractor's Program will not

affect the FFS Client's OHP benefit plan. Program eligible Clients, who choose not to participate at the time of initial contact by the Contractor, will remain eligible to participate, as defined in this Contract, at any future time.

b. Enrollment in the Contractor's Program by the FFS Client is voluntary. Contractor shall permit FFS Clients to opt-out of the Program at any time.

c. FFS Clients have the right to change their assigned registered nurse or primary care manager. A Program enrolled Client may change their assigned registered nurse or primary care manager using an oral or written request submitted to the FFS Client's current registered nurse or primary care manager, an OHA or DHS-APD supervisor.

d. Contractor may assign a new registered nurse or primary care manager to a FFS Client when there is a change in the FFS Client's acuity level. Generally, registered nurses or primary care managers based in the community will manage care for the higher acuity FFS Clients while lower acuity FFS Clients can be managed telephonically by a disease management coordinator.

e. Contractor shall not remove a Program enrolled Client from the Program based upon a negative change in the FFS Client's health status, utilization of medical services, or diminished mental capacity.

f. Contractor shall not remove a FFS Client from the Program due to uncooperative or disruptive behavior resulting from the FFS Client's special needs, except when that FFS Client's behavior and continued enrollment in the Program impairs the ability or safety of Contractor to provide services to the FFS Client. Contractor's removal of a FFS Client from the Program under these circumstances shall be immediately communicated to the OHA OHPCC Contract Administrator.

g. Contractor shall notify the FFS Client's primary care provider of the Client's enrollment in the Program.

~~**h.** It is understood by the parties to this Contract that at the time of the Effective Date of this Contract, OHA is in discussions with tribal representatives with respect to the provision of Care Coordination services to American Indian/Alaskan Native (AI/AN) FFS Clients. It is further understood and agreed to by the parties that at the conclusion of those discussions, OHA may, in its sole discretion, amend this Contract to exclude AI/AN FFS Clients from Contractor's services as specified by OHA. OHA reserves the right to: 1) require Contractor's continued provision of services to those AI/AN FFS Clients currently enrolled with Contractor as of the Effective Date of this Contract, if such Clients elect to continue to receive services from Contractor; and 2) close Contractor's enrollment of AI/AN FFS Clients as of a date to be specified by OHA. OHA further reserves the right to require Contractor's performance of IQA services, as set forth in Section 7 above, for all, or a portion of AI/AN FFS Clients, as specified by OHA. It is agreed by the parties that Contractor shall not be entitled to a per member per month fee for Care Coordination services for such AI/AN FFS Clients excluded from, or who elect not to receive Contractor's services. Contractor expressly agrees to execute an amendment to this Contract to implement this subparagraph~~

~~h. consistent with the spirit and intent of those tribal discussions and to cooperate in the transition of services for AI/AN FFS Clients.~~

10. Disenrollment.

a. Contractor shall discontinue efforts to contact or locate Program eligible Clients when the attempts have failed, as described in Section 9 Enrollment. FFS Clients not enrolled in Contractor's Program services will continue to receive the benefits of the Contractor's NAL and may be contacted by Contractor at a later date for possible enrollment in the Program.

b. Contractor may disenroll a FFS Client from the Contractor's Program when the FFS Client moves out of Oregon.

c. Contractor shall not disenroll a FFS Client due to uncooperative or disruptive behavior resulting from his or her special needs, except when that FFS Client's behavior and continued enrollment in the Program impairs the ability or safety of Contractor to provide the Program services to the FFS Client.

d. Contractor shall immediately communicate to the OHA OHPCC Contract Administrator when Contractor disenrolls a FFS Client. Contractor's disenrollment decision is subject to OHA review upon Client's request. Regardless of the procedures followed, the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which Contractor notified OHA.

e. Contractor shall advise the disenrolled FFS Client of Client's rights to appeal disenrollment from Contractor's Program to OHA.

11. Marketing and Communications.

a. General Provisions.

(1) All forms of Contractor's communications must meet the language requirements identified in this Section and be culturally and linguistically sensitive to FFS Clients with disabilities or reading limitations, including FFS Clients whose primary language is not English.

(2) OHA and DHS-APD shall approve, prior to distribution, any communication related to outreach, health promotion, and health education produced by Contractor, or Subcontractors, that is intended solely for FFS Clients and pertains to the Program services and benefits.

(3) OHA and DHS-APD will provide Contractor with the current logo or signature for a specific communication only when OHA, DHS-APD, and Contractor have determined the logo or signature is necessary for a particular document produced by Contractor for Program marketing and communications. OHA and DHS-APD will notify Contractor when there are changes to the logos.

(4) Contractor shall address any health literacy issues by preparing the communications at a 6th grade reading level, incorporating graphics when appropriate, using a 12-point font or larger, and utilizing alternate formats.

(5) Contractor shall make communications available in alternate formats for presentation to FFS Clients with disabilities. Standard alternate formats include Braille, large (18-point) print, audio narration, oral presentation, and electronic file along with other aids and services for other disabilities, including sign language interpretation and sighted guide.

(6) Contractor shall consult with OHA's Office of Equity and Inclusion for information on communication methods that are culturally specific and culturally competent.

b. Written Communications.

(1) Contractor shall develop the following written communications as needed to assist FFS Clients in understanding the requirements and benefits of the Program:

(a) Marketing brochures, pamphlets, newsletters, posters and fliers,

(b) Educational or instructional materials,

(c) Enrollment notices, and

(d) Informational materials.

(2) Contractor shall accommodate requests from OHA to translate written communications into the prevalent non-English language for the FFS Client.

(3) Contractor shall notify FFS Clients that written communication is available in alternate formats and how to access those formats.

(4) Contractor shall obtain OHA and DHS-APD approval to any changes in written communication to FFS Clients at least 30 calendar days prior to the effective date of the change.

c. Electronic Media.

(1) Contractor shall electronically provide to OHA for approval each version of the printed outreach package described in Section 8 Outreach and Engagement.

(2) At least 30 calendar days prior to use, Contractor shall provide to OHA for approval all website and web-based publications related to Contractor's Program.

d. Interpretation and Translation.

(1) Contractor shall provide certified, healthcare interpretation services free of charge to non-English speaking FFS Clients and their family members. Oral interpretation services apply to all non-English languages, not just prevalent non-English languages.

(2) Contractor shall translate written communications into the prevalent non-English language of the FFS Client and family members or caregivers when needed by the FFS Client.

(3) Contractor shall notify FFS Clients that interpretation and translation services are available and how to access the services.

e. Limitations for Marketing and Communications.

(1) Contractor shall not engage in door-to-door, telephone, or any cold-call marketing activities, promotions, or solicitations for any purpose beyond what is specified within the terms of this Contract, or as mutually agreed upon by OHA and Contractor for the benefit of Program eligible, FFS Clients.

(2) Contractor shall not contact FFS Clients at any time for reasons other than those described in this Contract without OHA's prior written approval.

(3) Contractor shall not make any assertion or statement, whether written or oral, that Contractor is endorsed by CMS, the federal or State government, or any other similar entity.

(4) Contractor shall not make any assertion or statement, whether written or oral, that the FFS Client must enroll in the Contractor's Program in order to obtain or maintain Oregon Health Plan benefits.

12. Evaluation; Quality Control and Process Improvement.

a. Contractor shall have written Quality Control and Process Improvement programs applicable to the Program. Contractor shall:

(1) Ensure its Quality Control and Process Improvement programs are implemented and maintained.

(2) Make its Quality Control and Process Improvement programs available to OHA when requested.

(3) Develop and maintain a Quality Control and Process Improvement system for the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments.

(4) Have Process Improvement or Quality Control strategies and measures that demonstrate the monitoring and evaluation of FFS Client satisfaction.

(5) Perform Quality Control and Process Improvement to identify Program service gaps and barriers to care, and implement corrective actions.

(6) Contractor shall develop and implement a minimum of one Quality Control or Process Improvement initiative per fiscal year that must be mutually agreed to by Contractor and OHA.

b. Contractor shall measure and report to OHA its Program equality related to health and cultural competency.

c. Contractor shall monitor Health Literacy to demonstrate improvement in FFS Client's participatory management skills.

d. Contractor shall provide direct supervision and performance management of its personnel using interpersonal and electronic processes including, but not limited to:

(1) Productivity and performance goals based upon position and key responsibilities.

(2) Comparative productivity relative to similar professional staffing or positions.

(3) Core staff behaviors such as attendance and punctuality.

(4) Random review of plans-of-care and interventions.

(5) Random silent monitoring of primary care managers and Disease Management and Intensive Care Management staff telephone calls on at least a quarterly timeframe.

(6) Discussion with community liaisons or supervisors in clinical facilities who have contact with Contractor's staff.

e. Contractor shall have documented systems and processes to monitor and ensure the quality of the Program's operation. Contractor's systems and processes must, at a minimum, include:

(1) Silent monitoring of Care Coordination, Disease Management, Intensive Care Management, and NAL staff telephone calls on a random basis.

(2) Telephonic monthly metrics reports including:

(a) Average time to answer or average speed of answer (ASA),

(b) Average call duration,

(c) Average duration on hold,

(d) Number of outgoing calls,

(e) Number of incoming calls, and

(f) Number of transferred calls.

f. Outcome Measurement

(1) Contractor shall perform critical analysis for evaluation of Contractor's Program.

(a) Contractor shall work with OHA to:

i. Establish mutually agreed upon baselines for results comparison.

ii. Monitor the expected clinical outcomes through claims data activity analysis.

iii. Establish targeted improvement on clinical outcomes.

(b) Contractor shall measure the degree of improvement from the baseline to the clinical outcome at the end of each 12-month service cycle.

(2) Contractor's health outcome measurements shall be aligned with the metrics utilized by the CCOs and required by OHA. Contractor shall evaluate and report the effectiveness and efficiency of Contractor's Program in meeting the applicable State health outcome metrics. The metrics can be found at http://www.oregon.gov/oha/Pages/metrix.aspx.

(3) Contractor shall use national and OHA metrics established for State Healthcare Outcomes Reform as the basis to determine mutually agreed upon measurements for the Program that include, but are not limited to, the following components:

(a) Evidence-based practices and strategies that improve health outcomes.

(b) Strategies and interventions to reduce medical costs.

(c) Reduction in hospitalization of ambulatory care sensitive conditions.

(d) Reduction in non-emergent utilization of emergency departments.

(e) Reduction in tobacco and chemical dependency.

(f) Reduction in under-immunized children and adults.

(g) Reduction in health and racial disparities.

(h) Cost effective Care Coordination, Disease Management, and Intensive Care Management services within OHP Medicaid parameters.

(i) Use of strategies and interventions that reduce or prevent the progression of chronic conditions or acute catastrophic events.

(j) Reduction in barriers to access and care from both the healthcare provider and FFS Client.

(k) Increase in the number of FFS Clients with a medical home.

13. Data, Records, and Reports.

a. Contractor shall create, prepare, and share documentation, data, metrics, and reports with OHA and DHS-APD for the following: Care Coordination Pre-management, Independent and Qualified Agent, Care Coordination, Disease Management, Intensive Care Management, and the NAL.

b. Contractor shall prepare and submit all data and documents in a format acceptable to OHA. Records, data, or reports submitted to OHA shall be revised and resubmitted as requested by OHA to OHA's satisfaction. OHA shall notify Contractor of the need to revise the contents of the records, data, or reports within seven calendar days of its receipt. OHA shall specify, in its written request to revise the contents, a length of time for Contractor to correct the unsatisfactory information.

c. Contractor and OHA agree that an electronic solution is needed for sharing and posting reports and data files. The parties shall collaboratively work toward a solution.

d. Contractor shall prepare and submit to OHA written Care Coordination and Independent and Qualified Agent status reports monthly, with the content and format agreed to by OHA and DHS-APD.

e. Contractor will document all NAL interactions and report the interactions monthly to the OHA OHPCC Contract Administrator. These metrics reports will include, but are not limited to, the number and nature of calls, types of interventions offered, referrals made, and resolution of calls.

f. Contractor shall prepare and submit to the OHA OHPCC Contract Administrator an annual written evaluation report of Program services performed.

g. Contractor shall prepare and submit annual and quarterly reports to the Health Systems Division leadership.

h. Contractor shall have access to OHA and DHS-APD FFS Client records and data applicable to the performance of its Work under this Contract.

i. Contractor shall ensure that FFS Clients may request and receive a copy of his or her records generated by the Contractor, and has the right to request that they be amended or corrected as specified in 45CFR Part 164.

j. OHA shall advise Contractor of the name and the physical address or email address of the recipient(s) of the data, records, and reports.

k. Contractor shall prepare and submit written quarterly Program reports including but not limited to:

(1) Total case load;

(2) Number, percentage and type of completed assessments;

(3) Number, percentage, and type of incomplete assessments;

(4) Number and type of interventions and follow-up activities;

(5) Number of FFS Client complaints, concerns, resolutions, and compliments;

(6) Number of provider complaints, concerns, resolutions and compliments;

l. Report Delivery Schedule.

(1) Weekly and monthly Program status update reports shall be delivered to OHA by the last business day of the week and month following the end of the subject week and month respectively. These weekly and monthly reports must be delivered using an application such as SharePoint®.

(2) Quarterly Program status update reports shall be delivered to OHA no later than 45 calendar days after the end of the previous quarter. Quarters are defined by the State's fiscal year as July 1 to September 30, October 1 to December 31, January 1 to March 31, and April 1 to June 30.

(3) Annual Program reports shall be delivered to OHA within 90 calendar days of the end of the previous fiscal year. Annual program reports must cover at least the period July 1 to June 30.

m. Standard and Custom Reports.

(1) Contractor shall prepare and submit a suite of standard written reports at no cost to OHA. Contractor shall determine the technology it will use to develop the standard reports and how the reports will be shared with OHA. The suite of standard reports shall be defined by mutual agreement of the parties or as requested by OHA. Standard reports are defined as those which require little or no customization by OHA or Contractor.

(2) Custom reports are those reports for one-time use or those not included on the standard reports list below. Contractor shall prepare and submit to OHA up to ten additional written custom reports from data available from Contractor's database, as requested by OHA. Requests for additional custom reports in excess of ten shall be invoiced at a cost of $150.00 per hour for custom report development. Contractor must obtain written prior-authorization from OHA for any custom reports.

(3) OHA shall prepare a list of standard reports to be included in the standard report package. Contractor shall review, with OHA participation, the standard report package on a regular basis. Reports may be added to the standard reports list and those that are deemed not applicable to OHA or no longer required by OHA, may be eliminated from Contractor's regular distribution.

n. Contractor shall assess, measure and report FFS Client satisfaction as follows:

(1) FFS Client "Success Stories" provided on a quarterly and annual basis that detail resolution based upon Contractor's interventions and activities.

(2) FFS Client satisfaction information obtained during annual FFS Client satisfaction survey on an annual basis.

o. FFS Clients Grievances, Complaints, and Compliments. Contractor shall submit to the OHA OHPCC Contract Administrator and the HSD Medicaid Complaints and Grievances Coordinator a written report, in a format and frequency agreed upon by the parties or as requested by OHA, that contains FFS Client complaints, grievances, and compliments, including, but not limited to, the event, date, parties involved, follow-up and resolution.

14. Policies and Procedures.

a. Contractor shall implement and maintain written policies and procedures to ensure the FFS Client's rights, including:

(1) Confidentiality of medical information.

(2) Guarding against disclosure of confidential information to unauthorized persons.

(3) FFS Client's consent prior to release of confidential information, unless authorization is not required.

(4) Information about the FFS Client's rights to confidentiality.

(5) Client's rights and responsibilities related to participation in the Program.

(6) Client's rights to an OHA or State of Oregon fair hearing process.

b. Contractor shall provide OHA and DHS-APD access to review Contractor's policies and procedures for its Program.

c. Contractor shall be responsible for auditing the Program policies and procedures for compliance with federal, State, Oregon Health Plan, Oregon Health Authority, and Department of Human Services' statutes, rules, regulations and guidelines.

d. Contractor's Program communication policies and procedures shall include the inclusion of a Client's rights and responsibilities statement. The statement must be available on Contractor's internet and in Contractor's hard copy publications. The Client rights and responsibilities are included in Exhibit F of this Contract.

e. Contractor shall develop and maintain policies and procedures for the management and resolution of FFS Client and healthcare provider complaints, grievances, and compliments. Contractor's policies and procedures shall document and resolve each complaint and grievance event. Complaints, grievances, and compliments shall be reported to OHA as described in Section 13, subsection n.

Contractor's complaint and grievance policies and procedures shall not restrict any FFS Client's right to a State of Oregon fair hearings and appeals process.

15. Personnel.

a. Contractor shall ensure that Contractor's or Subcontractor's professional staff have and maintain the required education, experience, qualifications, licenses, and credentials for healthcare professionals in the positions to which they are assigned by Contractor, or Subcontractor.

b. Contractor shall maintain the operational capacity and staff levels to review complex OHP medical cases by appropriate healthcare staff during normal business hours of 8:00 a.m. to 5:00 p.m., Pacific Time, Monday through Friday, including State of Oregon and federal holidays.

c. Contractor shall have a contingency plan to manage any turnover in staff that has direct contact with FFS Clients; and to maintain an appropriate case manager-to-FFS Client ratio, to achieve the required outcomes as described in this Contract, as the Client populations fluctuate.

d. Contractor shall ensure that Contractor's telephone, on-site or video language service interpreters are qualified and certified to Oregon standards and comply with OAR 333-002-0000.

e. Key Persons. Contractor's Key Persons shall include the following positions. Contractor shall immediately notify OHA of any changes in its Key Persons. Individuals in the positions of privacy and security officer ~~and Native American liaison~~ may be less than 1.0 FTE or may serve other roles in the organization.

(1) Executive Director. The executive director shall be responsible for overall operations and efficiency.

(2) Clinical Operations Manager. The clinical operations manager shall be responsible for the day-to-day operations of the clinical services provided to all FFS Clients and the successful operation of the nurse triage and advice telephonic services. The clinical operations manager must have a Master's degree in a discipline related to the ~~Work~~ work or equivalent training and experience; and at least five years' experience. OHA reserves the right to review the equivalent training and experience to ensure it meets the needs of OHA.

(3) Medical Director. The medical director shall be responsible for developing and maintaining clinical protocols for FFS Clients, performing case reviews, and working with service providers and stakeholders in support of the OHP care coordination program. The medical director must have at least five years' experience as a medical director for an organization similar in size and scope to the Work under the Contract. The medical director position shall act in a consultative role for FFS Clients in support of OHA's Provider Clinical Support Unit and the Medicaid Medical Director.

(4) Privacy and Security Officer. The privacy and security officer shall be solely responsible for assuring HIPAA requirements are met and information systems are secure.

~~(5) Native American Liaison. The Native American liaison shall serve as the sole point of contact for the OHA tribal coordinator and attend all tribal meetings with the OHA tribal coordinator.~~

~~(6)~~**(5)** Behavioral/Mental Health Assessments Manager. The behavioral and mental health assessments manager shall be accountable for all of the 1915(I) functions and all independent assessments for HCBS Recipients, and similar assessments for other FFS Clients required by OHA or DHS. This position must be a Licensed Qualified Mental Health Professional, with a master's degree, and have at least five years' experience with Medicaid populations.

f. Staffing for the Program.

(1) General Care Coordination. Contractor shall provide a qualified multidisciplinary team of registered nurses, primary care managers, social workers, disease management coordinators, and other licensed professionals as required for the Program.

(2) Field-based Staff. Contractor shall schedule field-based staff who may include registered nurses, social workers, provider-outreach staff, or community outreach staff to regularly visit high-volume or high utilization Medicaid fee-for-service hospitals and emergency departments, and federally qualified health centers.

(3) Field-based Staff Duties. Contractor shall ensure its field based staff duties include, but are not be limited to, the following:

(a) Communication with FFS Clients, healthcare providers, healthcare facilities, OHA, and family and caregivers regarding the FFS Client's healthcare and the development of plans-of-care and service plans that meet the FFS Client's needs.

(b) Responsibility to provide feedback to primary care physicians on FFS Client's status and progress.

(c) Provision of Case Management, Care Coordination, Disease Management, Intensive Care Management, interventions,

assessments, education, and other clinically-based activities for FFS Clients.

(d) Performance of in-person, telephonic, text, E-mail, and any computer based care management tools for assigned FFS Clients.

(e) Assistance and follow-up services with health-related, symptomatic, and emergent care calls received by the NAL.

(4) Care Management Coordinators. Contractor shall ensure its care management coordinators duties include, but are not limited to:

(a) Answer inbound NAL calls as described in Section 6 Nurse Triage and Healthcare Advice Line.

(b) Work with registered nurses and primary care managers to ensure Program services and supports are in place for FFS Clients.

(c) Communicate with community resources, healthcare providers and OHA regarding FFS Clients care coordination needs.

(d) Assist FFS Clients in scheduling appointments with physicians and specialists.

(e) Provide non-clinical assistance and self-management support to FFS Clients.

(f) Support the FFS Client-focused medical home concept.

(g) Conduct FFS Client needs assessments.

(5) Intensive Care Management. Contractor shall provide teams of primary care managers and care management coordinators for FFS Clients who meet ICM criteria based upon a health stratification process and risk assessment. Contractor's ICM registered nurse case manager duties include, but are not be limited to, the following:

(a) Develop and maintain relationships with hospital and clinic personnel for utilization review of contractor(s) for OHA.

(b) Develop systems for early intervention and coordination of discharge planning with hospitals.

(c) Provide FFS Client care management for complex cases and high utilizers of hospital emergency department services.

(d) Communicate with healthcare providers regarding FFS Client treatment needs and development of plans-of-care.

(e) Responsibility for medical records review, knowledge of individual ICM FFS Client's mental and physical history, and be able to articulate FFS Client's history and communicate clinically to primary care physicians

(f) Provide Care Coordination and Intensive care management, assessment, education and other clinically based activities for FFS Clients.

(g) Perform in-person or telephonic Care Coordination.

16. Information Systems; Technology.

a. Contractor shall comply with, and require any Subcontractors to comply with, the information security requirements imposed by OHA or DHS. Contractor shall maintain security of equipment and storage of all information assets accessed through this Contract to prevent inadvertent destruction, disclosure, or loss.

b. OHA will provide Contractor with access to the claims information to support the Work indicated in this Contract. Contractor shall adhere to established OHA policies relating to access to this claims information including those described in Exhibit A Part 4, Section 8 HIPAA Compliance and Exhibit B Section 15 Information Privacy/Security/Access. Contractor shall complete an Individual User Profile request for each person for whom access is requested.

c. Contractor shall have an information security risk management plan and Contractor shall ensure the plan:

(1) Has established privacy and security measures that meet or exceed the standards established by this Contract and in accordance with OHA and DHS Privacy and Information Security Incident policies.

(2) Documents Contractor's privacy and security measures.

Contractor shall make its security risk management plan available to OHA for review upon request.

d. Contractor's information systems shall have the capacity and the capability to exchange information or claims data with OHA and DHS-APD for the number of FFS Clients eligible for OHP Care Coordination services and have the ability to increase capacity and capability as the need for services increases for the term of this Contract. Contractor shall have the computer capacity and capability to securely accept and transfer data using Secure File Transfer Protocol (SFTP).

e. FFS Client Management System. Contractor will use software applications or other information systems or assets for the selection, referral, and engagement of Program FFS Clients. Contractor shall ensure the proper handling, storage, and disposal of any information assets obtained or reproduced, when the authorized use of that information ends, consistent with the record retention requirements otherwise applicable to this Contract.

f. Contractor shall have systems to monitor the operation of Contractor's Program that include silent monitoring of care managers or coordinators, NAL, Disease Management, and Intensive Care Management telephone calls; and can create monthly metrics reports of the Contractor's NAL activity as required under Section 13 Data, Records and Reports.

g. Contractor shall have systems to assist in supervising and managing the performance of its personnel as it applies to the Program.

h. Work performed under this Contract requires Contractor to have access to the Chronic Disease Payment System (CDPS) and the Medicaid Management

Information System (MMIS). Contractor shall comply with Exhibit B Section 15 Information Privacy/Security/Access.

17. Advance Directives.

Contractor shall support adults having advance directives to assist in guiding their health care decisions. ~~Contractor shall comply with 42 CFR Part 422.128 for maintaining written policies and procedures for advance directives. This includes compliance with 42 CFR 489, Subpart I "Advance Directives" and OAR 410-120-1380, which establishes, among other requirements the requirements for compliance with Section 4751 of the Omnibus Budget Reconciliation Act of 1991 (OBRA) and ORS 127.649, Patient Self-Determination Act.~~

a. Contractor shall maintain written policies and procedures concerning advance directives with respect to all adult FFS ~~Clients~~ members receiving ~~healthcare~~ services.~~by Contractor~~.

b. Contractor shall provide adult ~~Clients~~ members with ~~written~~ information on advance directives and where to receive additional information on completing an advance directive. ~~policies and include a description ofthe Oregon law~~. The ~~written~~ information provided by Contractor must reflect changes in Oregon law as soon as possible, but no later than 90 calendar days after the effective date of any change to Oregon law.

~~**c.** Contractor must also provide written information to adult FFS Clients with respect to the following:~~

~~(1) Their rights under Oregon law; and~~

~~(2) Contractor's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.~~

~~(3) The Contractor must inform FFS Clients that complaints concerning noncompliance with the advance directive requirements may be filed with OHA.~~

~~**18. Use of OHA Facilities and Equipment.**~~

~~**a.** OHA and Contractor agree that some of the Work under this Contract can best be accomplished when Contractor's staff is in the same location as OHA staff. OHA shall identify the OHA facilities and equipment Contractor shall use to accomplish this onsite Work.~~

~~**b.** OHA shall provide facilities acceptable to Contractor and that support the staffing requirements of Contractor for the Work. Contractor shall be responsible for parking for Contractor's staff. OHA facilities shall be available to Contractor for the term of the Contract.~~

~~**c.** OHA and Contractor agree the office equipment, office furniture, telephones, and work stations shall be standard, commercial quality.~~

~~**d.** Contractor shall provide computers for their staff and shall identify any information system requirements. Contractor's computers that need to be connected to the State LAN/WAN will utilize OHA's process for obtaining~~

~~connectivity to statewide LAN and email. Contractor shall provide PC support technicians to support Contractors computers. Contractor's support technicians will work with OHA-DHS Service Desk technical support to resolve any PC or network support problems.~~

~~e.~~ ~~OHA will provide the internal and external telecommunications lines that are part of OHA's network. OHA will provide State network connection equipment, which is the Ethernet interface and firewall to the internal OHA network. OHA is responsible for all implementation and management of its internal topology, including firewall and Local Area Network.~~

18.~~19.~~ Independent Contractor

a. Contractor shall act at all times as an independent contractor and not as an agent or employee of OHA. Contractor has no right or authority to incur or create any obligation for or legally bind OHA in any way. Although OHA reserves the right to evaluate the quality of the completed performance and determine and modify the delivery schedule for the services to be performed, OHA cannot and will not control the means or manner by which Contractor performs the services, except to the extent the means and manner in which the services are to be provided is specifically set forth in the applicable Statement of Work. Contractor is responsible for determining the appropriate means and manner of performing the services. Contractor acknowledges and agrees that Contractor is not an "officer", "employee", or "agent" of OHA (or any other agency, office, or department of the State of Oregon), as those terms are used in ORS 30.265, and shall not make representations to third parties to the contrary.

b. To maintain its independent contractor status and to mitigate the risk of Contractor's onsite staff being identified as State employees, Contractor agrees to the following:

(1) Contractor's employee identification badges shall clearly identify them as a Contractor.

(2) Contractor's employees shall have their own business cards.

(3) Contractor shall not approve deliverables, travel expenses or invoices, but may review them at the request of OHA.

(4) Contractor shall not be listed on OHA phone or email lists without the contractor status being highlighted.

(5) Contractor shall not be a voting member on solicitation evaluation committees, shall not attend normal OHA staff meetings, and shall not participate in OHA employee awards or recognition programs unless specified in this Contract.

(6) Contractor shall not request reimbursement or be paid for business expenses, including travel, unless specified in this Contract.

(7) Contractor's email signature should not suggest Contractor's staff is representing OHA without designating they are a contractor.

(8) OHA shall not train Contractor's staff or reimburse Contractor for training, or provide orientations for Contractor's staff unless specified in this Contract.

(9) OHA shall provide those facilities and equipment, as specified in Section 18 Use of OHA Facilities and Equipment, required for Contractor to complete the Work.

ATTACHMENT 2:
Amendments to Exhibit A Part 3 – Payment and Financial Reporting

EXHIBIT A

Part 3
Payment and Financial Reporting

1. Invoicing.

a. Contractor shall send all invoices to OHA's Contract Administrator at the address specified on page one of this Contract, or to any other address or designee as OHA may indicate in writing to Contractor.

b. Contractor shall submit to the OHA Contract Administrator by the 15th of each month an invoice for contracted services rendered the previous month. The monthly invoice shall be accompanied with reports in a mutually agreed upon format, that detail eligibility counts to substantiate the billing amount

c. Invoices shall include the total amount invoiced to date by the Contractor prior to current invoice. Contractor will note in the appropriate invoice when one-third and two-thirds of the maximum not-to-exceed amount is reached.

2. Travel and Other Expenses.

OHA will not reimburse Contractor for any travel or additional expenses under this Contract.

3. Provider Payments.

Contract does not include contracted service provider networks and Contractor will not be the payer of medical treatments or procedures rendered to the FFS Client.

4. Method of Payment.

a. Payment for all work performed under this Contract shall be subject to the provisions of ORS 293.462 and shall not exceed the maximum not-to-exceed amount in Section 3. Consideration. The not-to-exceed amount is budgeted according to the following:

Contract Not to Exceed Amount (NTE)			**$27,289,270.00**
Service	**Unit Measure**	**Unit Rate**	**Not to Exceed**
1915(i) Evaluation/Reevaluation	**1 Service**	**$57.75**	**$7,729,663.00**
1915(i) Person Centered Plan Development	**1 Service**	**$107.25**	
AFH- Medical Appropriateness Review	**1 Service**	**$110.00**	

RTH/F- Medical Appropriateness Review	**1 Service**	**$115.00**	
SRTF- Medical Appropriateness Review	**1 Service**	**$125.00**	
Behavioral Health Prior Authorization by QMHP	**1 Service**	**$135.00**	
Medical review/consult by MD	**1 Service**	**$650.00**	
Treatment Episode Monitoring AFH/RTH/RTF	**1 Service**	**$90.00**	
Treatment Episode Monitoring SRTF	**1 Service**	**$115.00**	
Concurrent Review – Inpatient Hospital	**1 Service**	**$605.00**	
Monthly Residential Census and report	**1 Service**	**$2,000.00**	
OSH Conflict Free case management	**1 hour**	**$96.00**	
FFS Conflict Free case management	**1 hour**	**$96.00**	
Nurse Triage and Advice Line	**1 Month**	**$29,320.00**	**$1,055,520.00**
Care Coordination services	**1 per member per month**	**$3.90**	**$16,848,000.00**
Prior evaluation/Authorization services	**1 Month**	**$47,250**	**$992,250.00**
Optional Pay for Performance			
Area	**Target**	**Incentive**	**Not to Exceed**
OHA Shall award contractor a one time performance payment for each patient assisted to discharge from the Oregon State Hospital when the performance target is met.	**Discharge less than 30 days from determination of ready to transition**	**$500.00 per patient per discharge**	**$5000.00 per month**
	Discharge less than 25 days from	**$700.00 per patient per discharge**	**$7000 per month**

	determination of ready to transition (RTT)		
	Discharge less than 20 days from determination of ready to transition (RTT)	**$800.00 per patient per discharge**	**$8000 per month**
	Discharge less than 15 days from determination of ready to transition (RTT)	**$1000.00 per patient per discharge**	**$10000 per month**
Secure Residential Treatment (SRTF) Utilization	**Maintain 180 day average length of stay for members in SRTF**	**$1000 per member assisted to discharge to a lower level of care from an SRTF**	**$10,000 per month**
***The one time pay for performance will account for Recipient maintaining a successful lower level (least restrictive placement) for 180 days. If a Recipient returns to RTT within 180 days of initial placement by Contractor, Contractor will not be eligible to receive an additional performance payment for that Recipient if the Recipient returns to the Oregon State Hospital within 180 days of step down.**			

~~(1) Nurse Triage and Advice Line.....$1,055,520.00~~

~~(2) Care Coordination Services .....$16,848,000.00~~

~~(3) Independent and Qualified Agent Services.....$7,272,000.00~~

~~OHA will pay the Contractor based on the rate structure listed below:~~

~~(1) To provide the Nurse Triage and Advice Line ..... $29,320.00 per month~~

~~(2) To provide Prior evaluation/Authorization services ..... $47,250 per month~~

~~(3) To provide Care Coordination services ..... $3.90 per member per month~~

~~(4) To provide IQA Services .....Refer to Exhibit F Attachment 4~~

5. Budget Neutrality.

Contractor must demonstrate that the Program is at least budget neutral, in that the Program will save enough money in health care costs to pay for itself. All rates paid for services will be evaluated by OHA and DHS-APD and are subject to evaluation of cost-effectiveness by the Centers for Medicare Services (CMS). Contractor must work to reduce overall Program expenditures. OHA will continue to pay all medical claims for services provided to Clients and will track utilization of services prior to Contractor's Program implementation and on a quarterly basis, according to CMS rules under waivered programs. Contractor and OHA will develop a mutually acceptable budget neutrality methodology document to detail the process, timetable, exclusions, and other parameters of the budget neutrality calculation. The Contractor will not assume financial risk for budget neutrality.

6. Liability for Payment.

Contractor understands and agrees that under no circumstances will a Client be held liable for any payments for any of the following:

a. Contractor's or Subcontractor's debt due to Contractor's or Subcontractor's insolvency;

b. Healthcare services authorized or required to be provided under this Contract to the Client, for which:

(1) OHA does not pay the Contractor; or

(2) Contractor does not pay a provider or Subcontractor that furnishes the services under a contractual, referral, or other arrangement; or

(3) Payments for covered services furnished under a contract, referral or other arrangement with Subcontractors, to the extent that those payments are in excess of the amount that the Client would owe if the Contractor provided the services directly.

Nothing in this Section limits Contractor, OHA, a provider or Subcontractor from pursuing other legal remedies that will not result in the Client's personal liability for such payments.

7. Risk of Insolvency.

a. Contractor assures that it is able to perform the Work required under this Contract efficiently, effectively and economically and is able to comply with the requirements of this Contract. As part of the proof of financial responsibility, Contractor shall provide assurances satisfactory to OHA, that Contractor's provision(s) against the risk of insolvency are adequate to ensure that Clients will not be liable for Contractor's debts if Contractor becomes insolvent.

b. Contractor shall provide solvency protection through maintenance of a restricted reserve account, or other means approved by OHA.

(1) Funds held in the restricted reserves, if any, shall be made available to OHA for the purpose of making payments to providers in the event of Contractor's insolvency. Insolvency occurs when Contractor is unable to pay debts when due, even if assets exceed liabilities.

(2) If any of the information that forms the basis for determining the manner or amount of a restricted reserve account is eliminated, changed, or modified in any manner, Contractor shall immediately notify OHA.

(3) Failure to maintain adequate financial solvency, including solvency protections specified pursuant to the requirements of this Contract, shall be grounds for termination, reduction in service area or enrollment, or sanction under this Contract, at OHA's sole discretion.

c. Contractor shall have procedures and policies to assure that Clients will not be liable for any debts or payment of claims in the event a Subcontractor becomes insolvent. All Subcontracts will include a clause that the Subcontractor will look only to the Contractor, and under no circumstances to the Client, for full payment of claims, and shall further require that this clause survives the termination of this Contract or Subcontract, including breach of Contract or Subcontract due to insolvency.

d. In the event that insolvency occurs, Contractor remains responsible for providing covered services for Clients through the end of the period for which it has been paid.

ATTACHMENT 3:

EXHIBIT D

Federal Terms and Conditions

General Applicability and Compliance. Unless exempt under 45 CFR Part 87 for Faith-Based Organizations (Federal Register, July 16, 2004, Volume 69, #136), or other federal provisions, Contractor shall comply and, as indicated, cause all subcontractors to comply with the following federal requirements to the extent that they are applicable to this Contract, to Contractor, or to the Work, or to any combination of the foregoing. For purposes of this Contract, all references to federal and state laws are references to federal and state laws as they may be amended from time to time.

1. **Miscellaneous Federal Provisions.** Contractor shall comply and require all subcontractors to comply with all federal laws, regulations, and executive orders applicable to the Contract or to the delivery of Work. Without limiting the generality of the foregoing, Contractor expressly agrees to comply and require all subcontractors to comply with the following laws, regulations and executive orders to the extent they are applicable to the Contract: (a) Title VI and VII of the Civil Rights Act of 1964, as amended, (b) Sections 503 and 504 of the Rehabilitation Act of 1973, as amended, (c) the Americans with Disabilities Act of 1990, as amended, (d) Executive Order 11246, as amended, (e) the Health Insurance Portability and Accountability Act of 1996, as amended, (f) the Age Discrimination in Employment Act of 1967, as amended, and the Age Discrimination Act of 1975, as amended, (g) the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, (h) all regulations and administrative rules established pursuant to the foregoing laws, (i) all other applicable requirements of federal civil rights and rehabilitation statutes, rules and regulations, and (j) all federal laws requiring reporting of Client abuse. These laws, regulations and executive orders are incorporated by reference herein to the extent that they are applicable to the Contract and required by law to be so incorporated. No federal funds may be used to provide Work in violation of 42 U.S.C. 14402.

2. **Equal Employment Opportunity.** If this Contract, including amendments, is for more than $10,000, then Contractor shall comply and require all subcontractors to comply with Executive Order 11246, entitled "Equal Employment Opportunity," as amended by Executive Order 11375, and as supplemented in Department of Labor regulations (41 CFR Part 60).

3. **Clean Air, Clean Water, EPA Regulations.** If this Contract, including amendments, exceeds $100,000 then Contractor shall comply and require all subcontractors to comply with all applicable standards, orders, or requirements issued under Section 306 of the Clean Air Act (42 U.S.C. 7606), the Federal Water Pollution Control Act as amended (commonly known as the Clean Water Act) (33 U.S.C. 1251 to 1387), specifically including, but not limited to Section 508 (33 U.S.C. 1368), Executive Order 11738, and Environmental Protection Agency regulations (2 CFR Part 1532), which prohibit the use under non-exempt Federal contracts, grants or loans of facilities included on the EPA List of Violating Facilities. Violations shall be reported to OHA, United States Department of Health and Human Services and the appropriate Regional Office of the Environmental Protection Agency. Contractor shall include and require all subcontractors to include in

all contracts with subcontractors receiving more than $100,000, language requiring the subcontractor to comply with the federal laws identified in this section.

4. **Energy Efficiency.** Contractor shall comply and require all subcontractors to comply with applicable mandatory standards and policies relating to energy efficiency that are contained in the Oregon energy conservation plan issued in compliance with the Energy Policy and Conservation Act 42 U.S.C. 6201 et. seq., (Pub. L. 94-163).

5. **Truth in Lobbying.** By signing this Contract, the Contractor certifies, to the best of the Contractor's knowledge and belief that:

a. No federal appropriated funds have been paid or will be paid, by or on behalf of Contractor, to any person for influencing or attempting to influence an officer or employee of an agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal grant, the making of any federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment or modification of any federal contract, grant, loan or cooperative agreement.

b. If any funds other than federal appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this federal contract, grant, loan or cooperative agreement, the Contractor shall complete and submit Standard Form LLL, "Disclosure Form to Report Lobbying" in accordance with its instructions.

c. The Contractor shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients and subcontractors shall certify and disclose accordingly.

d. This certification is a material representation of fact upon which reliance was placed when this Contract was made or entered into. Submission of this certification is a prerequisite for making or entering into this Contract imposed by Section 1352, Title 31 of the U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

e. No part of any federal funds paid to Contractor under this Contract shall be used, other than for normal and recognized executive legislative relationships, for publicity or propaganda purposes, for the preparation, distribution, or use of any kit, pamphlet, booklet, publication, electronic communication, radio, television, or video presentation designed to support or defeat the enactment of legislation before the United States Congress or any State or local legislature itself, or designed to support or defeat any proposed or pending regulation, administrative action, or order issued by the executive branch of any State or local government itself.

f. No part of any federal funds paid to Contractor under this Contract shall be used to pay the salary or expenses of any grant or contract recipient, or agent acting for

such recipient, related to any activity designed to influence the enactment of legislation, appropriations, regulation, administrative action, or Executive order proposed or pending before the United States Congress or any State government, State legislature or local legislature or legislative body, other than for normal and recognized executive-legislative relationships or participation by an agency or officer of a State, local or tribal government in policymaking and administrative processes within the executive branch of that government.

g. The prohibitions in subsections (e) and (f) of this section shall include any activity to advocate or promote any proposed, pending or future Federal, State or local tax increase, or any proposed, pending, or future requirement or restriction an any legal consumer product, including its sale or marketing, including but not limited to the advocacy or promotion of gun control.

h. No part of any federal funds paid to Contractor under this Contract may be used for any activity that promotes the legalization of any drug or other substance included in schedule I of the schedules of controlled substances established under Section 202 of the Controlled Substances Act except for normal and recognized executive congressional communications. This limitation shall not apply when there is significant medical evidence of a therapeutic advantage to the use of such drug or other substance of that federally sponsored clinical trials are being conducted to determine therapeutic advantage.

6. Resource Conservation and Recovery. Contractor shall comply and require all subcontractors to comply with all mandatory standards and policies that relate to resource conservation and recovery pursuant to the Resource Conservation and Recovery Act (codified at 42 U.S.C. 6901 et. seq.). Section 6002 of that Act (codified at 42 U.S.C. 6962) requires that preference be given in procurement programs to the purchase of specific products containing recycled materials identified in guidelines developed by the Environmental Protection Agency. Current guidelines are set forth in 40 CFR Part 247.

7. Audits.

a. Contractor shall comply, and require all subcontractors to comply, with applicable audit requirements and responsibilities set forth in this Contract and applicable state or federal law.

b. If Contractor expends $750,000 or more in federal funds (from all sources) in a federal fiscal year, Contractor shall have a single organization-wide audit conducted in accordance with the provisions of 2 CFR Subtitle B with guidance at 2 CFR Part 200. Copies of all audits must be submitted to OHA within 30 days of completion. If Contractor expends less than $750,000 in a federal fiscal year, Contractor is exempt from Federal audit requirements for that year. Records must be available as provided in Exhibit B, "Records Maintenance, Access".

8. Debarment and Suspension. Contractor shall not permit any person or entity to be a subcontractor if the person or entity is listed on the non-procurement portion of the General Service Administration's "List of Parties Excluded from Federal Procurement or Nonprocurement Programs" in accordance with Executive Orders No. 12549 and No. 12689, "Debarment and Suspension". (See 2 CFR Part 180.) This list contains the names of parties debarred, suspended, or otherwise excluded by agencies, and contractors

declared ineligible under statutory authority other than Executive Order No. 12549. Subcontractors with awards that exceed the simplified acquisition threshold shall provide the required certification regarding their exclusion status and that of their principals prior to award.

9. **Drug-Free Workplace.** Contractor shall comply and cause all subcontractors to comply with the following provisions to maintain a drug-free workplace: (i) Contractor certifies that it will provide a drug-free workplace by publishing a statement notifying its employees that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance, except as may be present in lawfully prescribed or over-the-counter medications, is prohibited in Contractor's workplace or while providing services to OHA clients. Contractor's notice shall specify the actions that will be taken by Contractor against its employees for violation of such prohibitions; (ii) Establish a drug-free awareness program to inform its employees about: The dangers of drug abuse in the workplace, Contractor's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation, and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations; (iii) Provide each employee to be engaged in the performance of services under this Contract a copy of the statement mentioned in paragraph (i) above; (iv) Notify each employee in the statement required by paragraph (i) above that, as a condition of employment to provide services under this Contract, the employee will: abide by the terms of the statement, and notify the employer of any criminal drug statute conviction for a violation occurring in the workplace no later than five (5) days after such conviction; (v) Notify OHA within ten (10) days after receiving notice under subparagraph (iv) above from an employee or otherwise receiving actual notice of such conviction; (vi) Impose a sanction on, or require the satisfactory participation in a drug abuse assistance or rehabilitation program by any employee who is so convicted as required by Section 5154 of the Drug-Free Workplace Act of 1988; (vii) Make a good-faith effort to continue a drug-free workplace through implementation of subparagraphs (i) through (vi) above; (viii) Require any subcontractor to comply with subparagraphs (i) through (vii) above; (ix) Neither Contractor, or any of Contractor's employees, officers, agents or subcontractors may provide any service required under this Contract while under the influence of drugs. For purposes of this provision, "under the influence" means: observed abnormal behavior or impairments in mental or physical performance leading a reasonable person to believe the Contractor or Contractor's employee, officer, agent or subcontractor has used a controlled substance, prescription or non-prescription medication that impairs the Contractor or Contractor's employee, officer, agent or subcontractor's performance of essential job function or creates a direct threat to OHA clients or others. Examples of abnormal behavior include, but are not limited to: hallucinations, paranoia or violent outbursts. Examples of impairments in physical or mental performance include, but are not limited to: slurred speech, difficulty walking or performing job activities; and (x) Violation of any provision of this subsection may result in termination of the Contract.

10. **Pro-Children Act.** Contractor shall comply and require all subcontractors to comply with the Pro-Children Act of 1994 (codified at 20 U.S.C. Section 6081 et. seq.).

11. **Medicaid Services.** Contractor shall comply with all applicable federal and state laws and regulation pertaining to the provision of Medicaid Services under the Medicaid Act, Title XIX, 42 U.S.C. Section 1396 et. seq., including without limitation:

a. Keep such records as are necessary to fully disclose the extent of the services provided to individuals receiving Medicaid assistance and shall furnish such information to any state or federal agency responsible for administering the Medicaid program regarding any payments claimed by such person or institution for providing Medicaid Services as the state or federal agency may from time to time request. 42 U.S.C. Section 1396a (a)(27); 42 CFR Part 431.107(b)(1) & (2).

b. Comply with all disclosure requirements of 42 CFR Part 1002.3(a) and 42 CFR Part 455 Subpart (B).

c. Maintain written notices and procedures respecting advance directives in compliance with 42 U.S.C. Section 1396(a)(57) and (w), 42 CFR Part 431.107(b)(4), and 42 CFR Part 489 subpart I.

d. Certify when submitting any claim for the provision of Medicaid Services that the information submitted is true, accurate and complete. Contractor shall acknowledge Contractor's understanding that payment of the claim will be from federal and state funds and that any falsification or concealment of a material fact may be prosecuted under federal and state laws.

e. Entities receiving $5 million or more annually (under this Contract and any other Medicaid contract) for furnishing Medicaid health care items or services shall, as a condition of receiving such payments, adopt written fraud, waste and abuse policies and procedures and inform employees, contractors and agents about the policies and procedures in compliance with Section 6032 of the Deficit Reduction Act of 2005, 42 U.S.C. § 1396a(a)(68).

12. Agency-based Voter Registration. If applicable, Contractor shall comply with the Agency-based Voter Registration sections of the National Voter Registration Act of 1993 that require voter registration opportunities be offered where an individual may apply for or receive an application for public assistance.

13. Disclosure.

a. 42 CFR Part 455.104 requires the State Medicaid agency to obtain the following information from any provider of Medicaid or CHIP services, including fiscal agents of providers and managed care entities: (1) the name and address (including the primary business address, every business location and P.O. Box address) of any person (individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity; (2) in the case of an individual, the date of birth and Social Security Number, or, in the case of a corporation, the tax identification number of the entity, with an ownership interest in the provider, fiscal agent or managed care entity or of any subcontractor in which the provider, fiscal agent or managed care entity has a 5% or more interest; (3) whether the person (individual or corporation) with an ownership or control interest in the provider, fiscal agent or managed care entity is related to another person with ownership or control interest in the provider, fiscal agent or managed care entity as a spouse, parent, child or sibling, or whether the person (individual or corporation) with an ownership or control interest in any subcontractor in which the provider, fiscal agent or managed care entity has a 5% or more interest is related to another person with ownership or control interest in the provider,

fiscal agent or managed care entity as a spouse, parent, child or sibling; (4) the name of any other provider, fiscal agent or managed care entity in which an owner of the provider, fiscal agent or managed care entity has an ownership or control interest; and, (5) the name, address, date of birth and Social Security Number of any managing employee of the provider, fiscal agent or managed care entity.

b. 42 CFR Part 455.434 requires as a condition of enrollment as a Medicaid or CHIP provider, to consent to criminal background checks, including fingerprinting when required to do so under state law, or by the category of the provider based on risk of fraud, waste and abuse under federal law.

c. As such, a provider must disclose any person with a 5% or greater direct or indirect ownership interest in the provider whom has been convicted of a criminal offense related to that person's involvement with the Medicare, Medicaid, or title XXI program in the last 10 years.

d. Contractor shall make the disclosures required by this Section 13. to OHA. OHA reserves the right to take such action required by law, or where OHA has discretion, it deems appropriate, based on the information received (or the failure to receive information) from the provider, fiscal agent or managed care entity.

14. Federal Intellectual Property Rights Notice. The federal funding agency, as the awarding agency of the funds used, at least in part, for the Work under this Contract, may have certain rights as set forth in the federal requirements pertinent to these funds. For purposes of this subsection, the terms "grant" and "award" refer to funding issued by the federal funding agency to the State of Oregon. The Contractor agrees that it has been provided the following notice:

a. The federal funding agency reserves a royalty-free, nonexclusive and irrevocable right to reproduce, publish, or otherwise use the Work, and to authorize others to do so, for Federal Government purposes with respect to:

(1) The copyright in any Work developed under a grant, subgrant or contract under a grant or subgrant; and

(2) Any rights of copyright to which a grantee, subgrantee or a contractor purchases ownership with grant support.

b. The parties are subject to applicable federal regulations governing patents and inventions, including government-wide regulations issued by the Department of Commerce at 37 CFR Part 401, "Rights to Inventions Made by Nonprofit Organizations and Small Business Firms Under Government Grants, Contracts and Cooperative Agreements."

c. The parties are subject to applicable requirements and regulations of the federal funding agency regarding rights in data first produced under a grant, subgrant or contract under a grant or subgrant.